RISK MANAGEMENT WATCHWORD IS SUPPORT, NOT PUNISHMENT (PAGE 9)

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Meningitis vaccination continues at U of I

PAGE 2

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JANUARY 15 1993



Hospitals look for technology that doesn't break the bank

PAGE 12

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OF MEDICINE

Michelle Rodriguez (left) and JoAnn Birdzell, of Chicago's St. Elizabeth's Hospital, testify before Gov. Jim Edgar's Health Care Reform Task Force. See story, page 3.

CIMRO wins Medicaid review contract

PEER REVIEW: The newly appointed Illinois Medicaid UR body, the Central Illinois Medical Review Organization, is seeking physician reviewers throughout the state to assure local peer review. By Tamara Strom

[CHAMPAIGN] Having secured the Illinois Department of Public Aid contract for Medicaid review, CIMRO is concentrating on making the peer review process as physician-friendly as possible.

"Our organization has always been most cooperative with all physicians in the state," said CIMRO President Harold J. Kolb, M.D. "We've tried to see the practicing physician's point of view as much as possible. Instead of being punitive, we're an educational organization. That's been our objective from the very start, and I think it's why we got the IDPA contract."

CIMRO's goal in assuming responsibility for the new Illinois Medicaid review program is to provide feedback to physicians and eliminate hassles, said Marylyn Gagliardo, CIMRO chief executive officer. The contract covers both utilization review and quality review, she

(Continued on page 21)

INSIDE

Ending a doctor-patient relationship
PAGE 9

'Managed competition' likely focus of reform
PAGE 15



The prescription for noncompliance
PAGE 17

DEPARTMENTS

News Briefs.....2
Illinois Watch 4
Washington Watch 5
Commentary...6, 7
Letters 7
Case in Point....10
Classifieds 19

IDPA raises physician reimbursement rates

MEDICAID: Gov. Jim Edgar keeps his promise to restore the 5-percent across-the-board rate reductions imposed last year. By Tamara Strom

[SPRINGFIELD] Santa replaced last year's lump of coal in Illinois physicians' stockings with a rate increase for fiscal 1994.

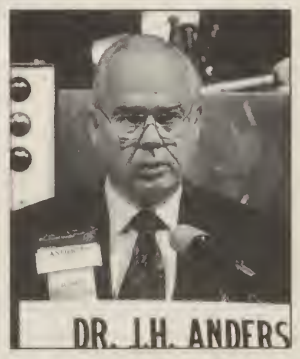
Effective Jan. 1, all doctors will see reimbursement rates restored with a 5-percent increase for services provided to Medicaid patients, Edgar announced in a Dec. 30 letter to Illinois physicians. The earlier 5-percent rate slash – necessitated by the state's fiscal crisis during the recession – was never meant to be permanent, Edgar said.

"In the midst of economic setbacks and cutbacks, my administration remains committed to providing health care for the indigent," Edgar wrote. "We are aware that this commitment succeeds only with the cooperation and participation of Illinois physicians. We truly value our effective working partnership with the medical community."

Illinois Department of Public Aid Director Phil Bradley said the state recognized the difficulty the rate cuts caused for physicians. "We made a commitment that as soon as we were able to restore that money, we would," Bradley told *Illinois Medicine*. "We are now in the financial position to do so. We at the department understand that we can't be

(Continued on page 23)

TED GRUDZINSKI/AMA





Illinois physicians figured prominently at the American Medical Association December interim meeting in Nashville. James H. Andersen, M.D. (above left), acted as chairman of the Reference Committee on Constitution and Bylaws, which considered the controversial ethical opinion on self-referral. Jere E. Freidheim, M.D. (above right), ISMS board chairman, served on Reference Committee F, which examines budgetary concerns, and AMA Board of Trustees and *JAMA* issues.

A PROFESSIONAL PERSPECTIVE

MEDICAL-LEGAL ISSUES FOCUS OF NEW COUNCIL, COLUMN

"Things are never what they seem," Gilbert and Sullivan wrote. And in the instance of medicolegal issues, seemingly innocent topics may in fact turn out to be a physician's own Bermuda Triangle.

Beginning with this issue, *Illinois Medicine* will publish a series answering the most common medical-legal questions asked by doctors. "These are queries that Society staff members most often field from doctors who are practicing on the front line, physicians who face the issues on a daily basis in examining rooms and operating theaters," said Clair M. Callan, M.D., chairman of the Illinois State Medical Society Medical Legal Council, which developed the responses. "These responses are designed to help physicians understand basic legal issues," Dr. Callan continued. "They are not a substitute for qualified legal counsel when specific situations warrant."

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Meningitis vaccination efforts continue at University of Illinois

CAMPUS OUTBREAK: Following eight cases of meningitis-related illness in a little more than a year, the University of Illinois will continue to provide prophylactic measures for students.
By Anna Brown

[URBANA] As students begin the spring 1993 semester at the University of Illinois at Urbana-Champaign, campus health officials have extended the free meningitis vaccination program for new and continuing students. The extension comes nearly two years after the deaths of two undergraduates within a three-day period and a year after the vaccine was first offered.

"We plan to offer the vaccine into the foreseeable future," said Judy Rowan, associate chancellor for public affairs. As of Dec. 15, 1992, Rowan said, 24,355 students had been immunized with the meningitis vaccine.

Between February 1991 and April 1992, eight students on the Urbana campus contracted meningococcal disease, and three died – the third more than a year after the first two. All cases were unrelated. Following the deaths of sophomores Gregory A. Manck and Brian McDonnell in February 1991, one case of meningococcemia a month was reported on campus from September 1991 through January 1992, Rowan said.

According to Lisa Jackson, M.D., medical epidemiologist for the U.S. Centers for Disease Control and Prevention, university outbreaks such as this are very rare, but isolated cases occur every few years. Dr. Jackson worked closely with the university, the Illinois Department of Public Health and the Champaign-Urbana Public Health District to develop a vaccination program. By April, 18,000 students had been immunized, including one – sophomore Robin Troupe – who later died of complications of meningococcemia.

"The vaccine is thought to be 85 percent to 95 percent effective and lasts three to five years," Rowan said. Although no new cases have been reported since Troupe's death in early 1992, vaccinations will continue.

The large number of cases at U of I are properly termed an outbreak, rather than an epidemic, Dr. Jackson said. "The definition of an outbreak is that new cases of the disease are not related to direct transmission." No secondary cases were found at the university, which was the reason the vaccination program was necessary. "If the students had known each other we

(Continued on page 22)

ILLINI MEDIA COMPANY



Marilynn Minor, a registered nurse at McKinley Health Center in Urbana, gives a bottle of rifampin to U of I student David Meyer during the 1991 outbreak of meningitis on the campus.

Medicare payment floor extended, with interest due

[CHICAGO] Continuing its campaign to encourage physicians to file electronic claims, the U.S. Health Care Financing Administration has instructed Medicare carriers to delay payment on "clean" paper claims until the 27th day after they are received.

But true to governmental form, there is a small snafu. Due to a presidential veto, HCFA will also have to pay interest on the delay.

The current payment floor for all clean paper claims (those for which no further information is required) is 14 days, with interest due if the claim is paid later than the 18th day after receipt of the claim. Effective Jan. 1 through Sept. 30, clean paper claims will not be paid until after the 27th day of receipt. But if payment goes out on the 28th day or later, according to a Midwest regional HCFA spokesperson, the 18th-day interest provision kicks in.

For example, a participating physician who files a paper claim with payment due on the 27th day after receipt will be paid 10 days' interest if payment is delayed until the 28th day. Interest payments on clean claims filed by nonparticipating physicians will begin on the 25th day after receipt.

The problem was caused by President Bush's veto of the federal tax bill, H.R. 11, which would have delayed interest payments until the 30th day after receipt. Saying the interest provisions contained in H.R. 11 will be reintroduced, the HCFA spokesperson added he hopes the problem will be cleared up early this year. ■

Cahokia ex-smoker contracts cancer, sues

[BELLEVILLE] In the first suit to be filed against a tobacco company since the U.S. Supreme Court ruled that warning labels will not shield cigarette manufacturers from damages, a dying Cahokia man seeks $3 million from the country's second largest tobacco manufacturer.

Charles Kueper, 51, whose lung cancer led him to sue R.J. Reynolds Tobacco Co., the Tobacco Institute and Reese Drug Stores, quit smoking in December 1990. He charges the defendants with conspiring to hide information about the dangers of smoking, and seeks compensatory and unspecified punitive damages.

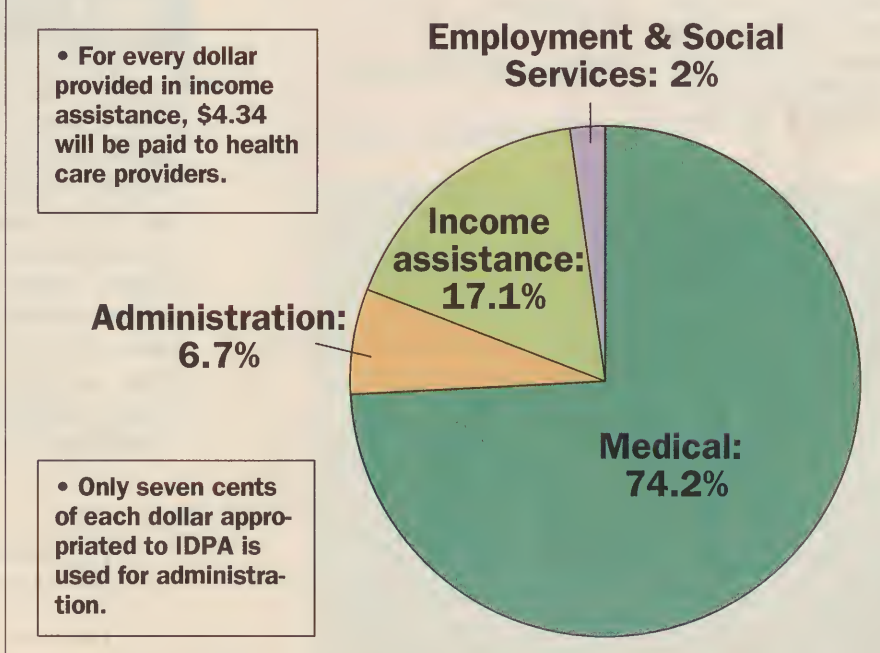
Kueper, who filed suit in a St. Clair County court, started smoking at 14 and averaged 1½ packs of cigarettes a day, according to media reports. Doctors say the retired Army veteran may die before spring.

A landmark anti-smoking suit that opened the door for cases such as Kueper's was dropped by the plaintiffs in November 1992, after 10 years of litigation.

In June 1992, the U.S. Supreme Court ruled that smokers must do more than prove cigarette advertising minimizes health hazards, but also said that warning labels would no longer protect tobacco manufacturers from lawsuits claiming smoking as the cause of health problems. ■

PHYSICIAN FACTS

IDPA appropriation totals by program – all funds*



* Fiscal year 1993
Source: Illinois Department of Public Aid

Hospital wins appeal in bypass case

[CHICAGO] A federal appeals court ruled Dec. 28 that "anti-dumping" laws did not apply in a lawsuit brought by a Chicago woman alleging that her infant daughter died after being routed away from the University of Chicago Hospitals. The panel based its decision on the facts that the infant did not actually enter the U of C Hospitals and that contact with a hospital-operated telemetry system is different from contact with a hospital emergency room.

The child, Lenise Nelson, died after U of C Hospitals staff told paramedics that no beds were available at its pediatric intensive care unit. The one-month-old infant died after being re-routed to another hospital.

A panel of the 7th Circuit U.S. Court of Appeals issued its original ruling Oct. 7, which found that federal laws discouraging "patient dumping" could be extended to patients who were not yet in the hospital and who were directed away from hospitals by radio telemetry operators.

Lawyers for the hospital filed written arguments asking that the full panel reconsider the case – a request supported by amicus curiae briefs from various medical organizations and hospitals. The federal appeals panel subsequently vacated its ruling. ■

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Reform task force mulling over options

ASSESSMENTS: Gov. Jim Edgar's Health Care Reform Task Force is finding limited alternatives for replacing the current health facilities assessment program. By Tamara Strom

[CHICAGO] If one thing is certain about the task force's position on the assessment program, it's the lack of consensus about the best way to fund Illinois' Medicaid system. While the task force almost unanimously concurs that no current services for Medicaid recipients should be reduced in fiscal 1994, there is no agreement about how to pay for those services.

"Failing to find alternative funding sources, some part of the assessment programs now in effect would have to be continued," said task force chairman Ernie Wish, a retired consultant. Acknowledging that without additional funding, health care facilities treating Medicaid patients would face reimbursement rate cuts of up to 30 percent, Wish told the task force at its Dec. 14 meeting that rate reductions would drive provider institutions "out of business." This would create a "severe financial strain," he said, adding, "I don't think we can offer that as a viable recommendation to the governor."

Task force member Susan Manilow, representing Mt. Sinai Hospital Medical Center, called on the group to adopt a statement of principles indicating that a "funding mechanism not disappear under any circumstances" and that "if no alternative [is found], this program stay in place."

But other task force members contended the program taxes some hospitals unfairly; as a result, they do not support continuing the assessments. Pam Meyer, chief executive officer of Edward Hospital in DuPage County, an institution with a small Medicaid payer mix that "loses" under the current assessment plan, submitted a list of new revenue sources for the group's consideration. Among the suggestions were an increase in personal income taxes, new payroll taxes on insured workers, premium taxes on out-of-state insurance companies and the restoration of sales taxes on food and over-the-counter drugs. The governor's aides staffing the task force reminded the group that Edgar would veto most of these.

Several group members pushed for increased "sin" taxes on the sale of alcohol and tobacco. While the governor did

(Continued on page 18)

Hearings air pros, cons of assessments

PUBLIC COMMENT: More than 40 individuals and organizations testified at Chicago and Springfield hearings. By Tamara Strom

[SPRINGFIELD] Nine-year-old Michelle Rodriguez had Illinois Department of Public Aid Director Phil Bradley in tears. During the Dec. 7 public hearing in Springfield, she recounted how she was accidentally shot in the back by a classmate last spring in her Chicago elementary school. Michelle received trauma care at Children's Memorial Hospital and rehabilitation therapy at the Rehab Institute of Chicago and St. Elizabeth's Hospital in her North Side Chicago neighborhood.

"They were great," Michelle said of the physicians, nurses and physical therapists who cared for her and now have her walking and running around like other little girls her age. Michelle said she liked going to St. Elizabeth's because "it was nearest to my neighborhood." Michelle's mother had difficulty taking Michelle downtown for the three-times-a-week treatment sessions ordered at the Rehab Institute to help her relearn to walk, so the family was referred to St. Elizabeth's.

JoAnn Birdzell, president and chief executive officer of St. Elizabeth's, traveled to Springfield with Michelle to tell the task force the importance of continuing the health care facilities assessment plan to fund Illinois' Medicaid program. "We brought Michelle because we think she has a nice story to tell about why a hospital in [the] inner city is important to patients and to families," Birdzell said in explaining why she believes

(Continued on page 18)

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REPORT FOR *Illinois Physicians*

* *1993 Federal Employee Program (FEP) Benefits Changes* *

The 1993 benefit package for the Federal Employees Program (FEP) introduces a nation-wide preferred provider (PPO) network, reflecting a mainstream managed care philosophy emphasizing a cost-effective provider network design that encourages the use of preferred providers. Members of the FEP will receive a higher level of reimbursement when they receive care from preferred providers. Also included is a newly developed retail pharmacy network.

IDENTIFICATION CARD

FEP identification numbers, as shown on the sample card below, begin with the letter "R" followed by eight digits.



	HIGH OPTION	STANDARD OPTION
PHYSICIAN SERVICES	Including inpatient physician care, surgery, diagnostic services and routine screening services.	
PPO/Preferred Physician	• Pays 95% of Preferred Provider Allowance	• $200 deductible/Pays 95% of Preferred Provider Allowance
Participating Physician	• Pays 80% Usual, Customary, and Reasonable	• $200 deductible/Pays 75% of Preferred Provider Allowance
Non-Participating Physician	• Pays 80% Usual, Customary, and Reasonable	• $200 deductible/Pays 75% of Preferred Provider Allowance
	• The member is responsible for the difference between the Usual, Customary, and Reasonable and the physician's actual charge for services provided by non-participating physicians.	
OFFICE VISITS	Including home and office visits. This includes office visits in conjunction with the covered routine screening tests when the provider is a preferred physician.	
PPO/Preferred Physician	• $10 copayment	• $10 copayment
ROUTINE (SCREENING) SERVICES	In addition to current benefits for routine mammograms and pap smears, two new preventive screening services have been added for 1993. These tests are the Prostate Specific Antigen (PSA) test or prostate cancer screening and the fecal occult blood test for colorectal cancer screening.	
PPO/Preferred Physician	• $10 copayment	• $10 copayment
EMERGENCY CARE	Outpatient accidental injury care.	
	Pays 100% for hospital and physician services rendered within 72 hours of injury.	

PRECERTIFICATION FOR ALL FEP SUBSCRIBERS

Preadmission certification for all FEP subscribers continues to be applicable. Please call the Medical Services Advisory (MSA) Program at the telephone numbers listed below.

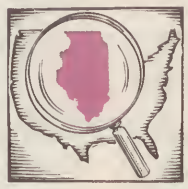
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Telephone number: (800) 972-8382

Medical Services Advisory
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Telephone number: (800) 227-6591

Cooperation yields pilot narcotic regulation program

TRIP SCRIPTS: Illinois State Medical Society efforts helped convince DASA to look for alternatives to raising fees to cover budget shortfalls. By Tamara Strom

[SPRINGFIELD] Faced with layoffs and shrinking resources, the Illinois Department of Alcohol and Substance Abuse considered increasing the fees physicians pay for Schedule II drug triplicate prescription pads. But input from organized medicine encouraged the department to seek other options, ultimately leading to the creation of a pilot program to test electronic transfer of prescription copies to DASA.



The triplicate prescription program functions as a check to assure that if physician prescription pads are stolen, they are not used to obtain narcotics illegally. Physicians currently pay $10 for 100 triplicate forms valid for two years from the date of issue. The department had considered raising the price to $30 for 100 forms, but DASA rejected that idea, opting for the pilot instead.

"Physicians will still have to write out a prescription pursuant to the law for Schedule II drugs," said DASA Director Jim Long. "But because of this innovative new program, physicians will not have to pick up [additional] costs of the [regulatory] program. We're sensitive to the fact that physicians – while they support the program – don't like to pay for that regulation."

Under the Illinois Controlled Substances Act, physicians are required to use triplicate forms to write prescriptions for Schedule II drugs (narcotics), and the department must monitor this drug use by collecting one copy of the form from the pharmacy that dispenses the drug. In addition, the pharmacy and the prescribing physician keep one copy each.

Manually sending a copy to the department and subsequently processing the information in Springfield is costly

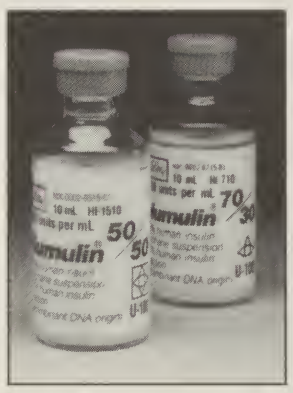
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State law cautions 'sun' worshippers

TANNING: New regulations require warnings for users of indoor tanning facilities. By Tamara Strom

[SPRINGFIELD] Illinois citizens walking around this winter with golden complexions acquired in tanning booths will soon know the dangers of their quest for the perfect tan, according to regulations issued in December by the Illinois Department of Public Health.

"Tanning booths expose users to the same type of ultraviolet radiation as natural sunlight and should not be considered risk free," said IDPH Director John R. Lumpkin, M.D. "Repeated and lengthy overexposure can cause skin cancer, eye and skin injury, sunburn and allergic reactions. With these new regulations, consumers will have the safety information necessary to make an informed decision about using tanning booths."

The rules were generated to implement a 1991 state law, supported by the Illinois State Medical Society, calling for stricter monitoring of indoor tanning facilities. According to the regulations, all tanning facilities must obtain operating permits and undergo an annual IDPH inspection to assure they adhere to safety and sanitation specifications. Warning signs detailing the dangers of ultraviolet radiation must be posted near tanning equipment, and all indoor "sun-seekers" must receive a written copy of the warning at least once a year.

In addition, the law prohibits children under 14 years of age from frequenting these tanning parlors. Patrons aged 14 to 17 must have written permission from a parent or guardian to use the tanning booths. The law requires all tanners to use protective eye wear and limits them to a maximum of one session every 24 hours.

Facilities are required to keep a confidential file for all patrons listing any medications, cosmetics, toiletries and other substances they use that could cause a photosensitive reaction, IDPH said.

All facilities must apply for a permit by March 8; fees are $250 for the initial permit and $150 for subsequent annual certificates. Penalties for noncompliance range from a Class A misdemeanor (deeming the facility a "public nuisance") to daily fines up to $500. ■

Illinoisans capture key House posts

CLOUT: Illinois' influence in the U.S. Congress is strengthened with a Republican's election to a key party post and two Democrats' capture of top congressional committee spots. By Kevin O'Brien

[WASHINGTON] Clout is the term, and it means political influence. Through its congressional delegation, Illinois will have plenty of the special ingredient it needs to influence federal policy.

One House Democrat and one House Republican already occupy two of the more powerful positions in the Congress. U.S. Rep. Dan Rostenkowski (D-Chicago), is chairman of the all-powerful House Ways and Means Committee. Across the aisle, veteran U.S. Rep. Robert Michel (R-Peoria) is the House Minority Leader.

Add to these another Republican veteran's ascension to one of his party's leadership positions, a freshman congressman's appointment to the Ways and Means Committee, and another Democrat member's election as chairman of an Appropriations subcommittee, and the state's influence in national policy-making is considerably strengthened.

Republican U.S. Rep. Henry J. Hyde of Bensenville was elected chairman of the House Republican Policy Committee Dec. 7 by the 176-member Republican caucus.

The Policy Committee is composed of 34 members, including the eight House Republican leaders, elected regional representatives, 10 at-large members, and two representatives from each of the sophomore and freshman classes. It evaluates legislation moving through Congress and develops policy statements on those bills on which Republicans achieve a consensus.

As Policy Committee chairman, Hyde becomes the fourth-ranking member of the House Republican leadership. An eloquent spokesperson for conservative positions and a gifted orator, Hyde is expected to play a major role in articulating Republican opposition to legislation proposed by the Democrat-controlled Congress and the Clinton administration.

IN A COUP FOR THE Illinois delegation, one of the state's freshman congressmen, U.S. Rep.-elect Mel Reynolds (D-Chicago), will take a seat on Rostenkowski's Ways and Means Committee. With a pledge from House Speaker Thomas Foley (D-Washington) to appoint a freshman to the arguably most influential committee in Congress, Rostenkowski turned to one of three new Illinois representatives he could have picked.



Leadership positions held by U.S. Reps. Henry J. Hyde of Bensenville (left) and Richard J. Durbin of Springfield will bolster Illinois' influence in the U.S. House.

Reynolds is a Rhodes scholar who unseated veteran U.S. Rep. Gus Savage (D-Chicago) after several attempts. He will take the committee seat relinquished by another Illinois veteran representative, Marty Russo of Chicago, who lost his re-election bid to Chicago colleague William O. Lipinski. Redistricting put Democrats Russo and Lipinski in the same district for the 1992 election.

Rounding out Illinois' new list of congressional leaders is U.S. Rep. Richard J. Durbin (D-Springfield), who was elected chairman of the Appropriations Subcommittee of Agriculture, Rural Development, FDA and Related Agencies, which influences the appropriation of millions of federal dollars.

Most of the returning members of the Illinois delegation will retain their previous committee assignments. Committee assignments for the U.S. Senate are made in early January. ■

Clinton names HHS chief, Surgeon General

CABINET: President-elect Clinton announced his choices for Secretary of Health and Human Services and Surgeon General. By Kevin O'Brien

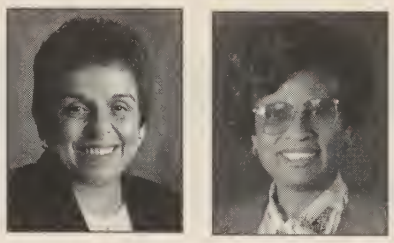
[LITTLE ROCK, ARK.] President-elect Clinton picked two women known for their aggressive, no-nonsense leadership to head the bureaucracy that manages the Medicare and Medicaid systems and to be "the nation's doctor."

Clinton Dec. 11 nominated Donna E. Shalala, 51, chancellor of the University of Wisconsin-Madison, to be secretary of the U.S. Department of Health and Human Services. And in a Dec. 24 press conference, he included in his last round of appointments M. Joycelyn Elders, M.D., as his choice for Surgeon General.

Shalala was assistant secretary for policy development and research in the U.S. Department of Housing and Urban Development during the Carter administration.

If confirmed by the U.S. Senate, Shalala will oversee the U.S. Health Care Financing Administration, which runs Medicare and Medicaid; the Social Security Administration; the Food and Drug Administration; the Public Health Service; the National Institutes of Health and other agencies.

Shalala is regarded as a skilled administrator of large bureaucracies. "I want to energize that huge HHS bureaucracy to demonstrate that government can be sensitive, caring and accountable," she said in accepting the Clinton nomination.



Donna E. Shalala (left) and M. Joycelyn Elders, M.D., will serve important roles in implementing President-elect Clinton's promised health care reforms.

Dr. Elders, 59, has been director of the Arkansas Department of Health since 1987. She was a professor of pediatrics at her alma mater, the University of Arkansas Medical Center, for more than 20 years. She has been an outspoken advocate of programs to combat social ills that affect health care.

"We must address the social problems impacting the health of our society, i.e., drugs, alcohol, homicides, suicides, accidents, AIDS and teen pregnancies," Dr. Elders said.

The post of Surgeon General is not of Cabinet rank. However, Dr. Elders is expected to be as visible as her two immediate predecessors, C. Everett Koop, M.D., who served in the Reagan administration, and Antonia C. Novello, M.D., who has been Surgeon General under President Bush. Dr. Elders' past association with Clinton makes it likely she will be involved in health care policy-making. In addition, Clinton said that Dr. Elders would also be an assistant secretary in HHS. ■

Opposition mounting for M.D. involvement in legal executions

LETHAL INJECTION: Health care groups are protesting proposed federal rules mandating physician participation in legal executions. By Tamara Strom

[CHICAGO] Physician groups, including the Illinois State Medical Society, are calling on the federal government to amend proposed rules that require doctors to participate in legally authorized executions and determine death of the inmates.

The American Medical Association, the American College of Physicians and other health care organizations expressed their concern about the doctor-participation provisions in the regulations during a Dec. 29 press conference in Chicago. Published Nov. 30 in the *Federal Register*, the rules included a 30-day comment period ending Dec. 30.

"It is highly unethical for physicians to participate in executions; and in turn, highly inappropriate for the federal government to suggest we do so," Thomas P. Houston, M.D., AMA preventive medicine and public health director, told reporters at the December briefing. "Requiring physicians to participate in executions goes against the very nature of the practice of medicine and what physicians believe is the compassionate delivery of care to their patients."

The physician groups took particular issue with references that "at least one physician selected by the Warden" be present during the execution and that a "physician or other qualified personnel" determine death.

Dr. Houston cited 1980 AMA policy declaring as unethical physician involvement in legal executions. And as recently as the December 1992 interim meeting in Nashville, the AMA House of Delegates unanimously adopted an ethical report clarifying and defining what constitutes physician participation.

ISMS House of Delegates policy condemns physician participation in executions as unethical. In most states, including Illinois, acting unethically is a violation of the state Medical Practice Act and is considered cause for disciplinary action.

During the 1992 legislative session, ISMS successfully supported changes in state law that eliminated a mandate for two physicians to witness executions. Efforts to erase provisions requiring a physician to pronounce death after lethal injection failed after the Illinois attorney general claimed removing the language was a de facto attempt to abolish the death penalty.

In written comments submitted Dec. 18 to the Federal Bureau of Prisons, ISMS expressed "concern" about the physician-specific provisions in the federal rules and recommended amendments to remove them. The comments reiterated the Society's commitment to remove the pronouncement of death provisions in the Illinois Code of Criminal Procedure.

During the Dec. 29 press conference, ISMS member William Gibbons, M.D., noted ISMS and AMA efforts to enforce the policies eliminating physician participation in executions. He, too, called for the federal rules to strike the references to physician involvement.

"To put on the books laws that are antithetical to Medical Practice Acts and the standards of the profession is just unacceptable," Dr. Gibbons said. "The standards of the profession demand respect from the law." ■

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EDITORIAL

The prospect of managed competition

The Democratic governor from Arkansas may have swept the electoral college, but President-elect Bill Clinton's health care proposal doesn't have the same kind of support from voters.

Three different polls taken around Election Day show that the top two factors voters cited as affecting their votes were "jobs/the economy" and "the federal deficit." Health care finished third, far behind the first choice, economy/jobs, and the deficit.

Those polled believed Gov. Clinton would do a better job than President Bush or Ross Perot when it came to providing affordable health care for all Americans, the survey said. But support for the governor did not extend to support for the governor's plan. Less than one-third were for the governor's plan. About a third supported President Bush's plan, while another third favored a Canadian-style health care proposal. This three-way split may indicate the complexity of Americans' feelings about health care.

When Americans are sick, they want the best care possible. And they want it without regard to cost. Nothing is too good – or too expensive – for the ailing American health care consumer and his/her family.

Health care reform will attempt to control costs, and this means both fewer machines, and more rigorous definitions of which conditions and patients will benefit from the available technology.

They want it now. The typical insured American patient expects instant attention. Americans don't wait cheerfully or willingly for health care. More efficient utilization of technology and health care resources is probably going to lead to waiting. Will the average American patient tolerate the delay as stoically as Canadians are said to do? Not likely.

And they aren't used to paying for it. Free, or practically free, health care coverage as a benefit of employment has become a given since the 1950s. Extensive coverage with little or no patient copayment or deductibles has effectively shielded the employed American health care consumer from the reality of health care costs. Managed competition must include patient financial participation in health care, to help patients make informed choices.

Elements of President-elect Clinton's plan that could – and probably should – go forward almost immediately include reform of the insurance industry, waiver of ERISA protections and the institution of malpractice reforms. But it's going to take more than televised "town meetings" on CNN to convince typical insured American patients that health care reform should and does include their waiting or paying for it.

PRESIDENT'S LETTER

Insight is more popular than plain old sight

By Arvind K. Goyal, M.D.



Confidentiality goes out the window when patients are told benefits will be denied if the information is not available.

A company president called in all eight of his department heads. At the outset he emphasized that what followed was a confidential discussion. "I understand," he announced, "that many of you have been dating Miss Jones in the office. Is that true?" Seven of the eight executives raised their hands. The boss then glared at the eighth man and demanded the truth. "Are you sure?" "Yes, I am," was the reply. "All right then," came the punch line. "You fire her."

It is well known that results of a confidential meeting are known an hour later but what may have happened in a public session, one reads in the next day's paper. Confidential news travels faster than sound or electricity – a fact of science yet to make the textbooks.

I was at a dinner meeting with officers and members of a county medical society recently when someone mentioned a physician with HIV infection, who was admitted to an area hospital. By the time he was discharged almost all physicians, hospital employees and many of his patients knew of his diagnosis and troubles that came with. Litigation for breach of confidentiality against the hospital and others involved in his care was in progress.

I immediately thought of an ex-tennis champion, a private citizen, who had also been chased by the media into notoriety on account of his HIV infection, information he had carefully guarded until that time.

This scenario is not just confined to the virus that causes AIDS. A patient of mine told me recently about a surgeon in our area who was operated on for lung cancer at a university hospital, some 20 miles away. I happened to know the surgeon, a colleague of mine. The patient had never met him. It was clear my patient was better informed than I! But, how?

I also remember the time I found a stranger sitting at a crowded nursing station in the hospital, reviewing my patient's chart. Upon inquiry, I learned she was an insurance company representative who routinely reviewed charts of all hospitalized patients insured by that company. Nobody else at the hospital, including the administrator, the nurses, the utilization review committee chairman, the patient's attending physician (myself) or the patient herself had been aware of her dedicated efforts for the insurance company. She had been paid week after week for snooping on hospitalized patients' charts. I also happen to have witnessed a variety of paramedical aides on a nursing floor reviewing patients' charts from time to time.

The day after that county medical society meeting, I was in the doctors' lounge of our hospital gazing at the list of surgeries scheduled for that day. I had seen such lists before. Only this time, I had a different perspective. The list was full of information: the names of the surgeon and anesthesiologist; the planned surgery; the patient's name, age and sex; and some other identifying information. Everything was there except the surgeon's age, religion and diet. That list was posted on every bulletin board in the hospital – so everyone knew what was happening! Each nursing unit got a list, as did each surgeon on staff. I guess anybody could look that list up – that is, anybody who wanted to stay informed!

Similar is the risk posed by insurance company Peeping Toms, utilization review personnel, insurance claim forms and data with identifiers being shifted from one source to the next. There are those who want all medical information then and there. Information in any computer could be accessed – by a party who so insisted! There is evidence that confidential medical information available to one insurance company is routinely available for use by other companies for underwriting purposes.

Patients resent a breach of confidentiality to a certain point, but confidentiality goes out of the window when they are told benefits will be denied if the "required" information is not available to the "payer" of medical care.

Most physicians consider it unethical to breach or share with anybody information gained in the course of their professional work. The hospitals, nursing homes, and other places where patients receive medical care, and payers and managers who administer benefits associated with medical care should review their policies to insure that patient charts and other confidential medical information remain accessible only to treating physicians, nurses and other medical personnel directly involved in caring for a patient.

If our patients' medical conditions become public information as a matter of practice, I am afraid some people may be deterred from getting needed medical care early on! And we can't have that.

GUEST EDITORIAL

The best care other people's money can buy

By James P. Weaver, M.D.

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A ruptured abdominal aortic aneurysm. That's what he came into the hospital with. Ten in the evening, and I spent the whole night saving his life.

I was amazed that, at 70 years of age, he even made it to the intensive care unit. His full recovery turned out to be a gargantuan struggle. Two months in the intensive care unit. Transferred to the floor. Pneumonia. Back to the ICU for two weeks. Back to the floor. CAT scans. Looking for abscesses. Nine consultants. He was given all the technology that money can buy. And he made it.

The end of the struggle was not as glamorous. It was a slow process of winding down the antibiotics, winding up the physical therapy, and feeding him enough to help him regain his strength. There were so many obstacles to his recovery, but it was in dealing with his feeding problems that I encountered the most underrated of them all: the Ultimate Cost Container, a cost-conscious patient.

We will never satisfy the public's demand for something as valuable as medical care when it is offered "free" of charge.

It came as a complete surprise. During the 3½ months of hospitalization, money had never entered the discussion. No one brought it up – not friends, not family, not the patient. Then it happened.

I had tried to get Mr. X, as I shall call him, to use his false teeth to eat, but he had lost so much weight that they didn't fit. I suggested that we call in a dentist, and he agreed. The dentist came that day. On evening rounds I asked Mr. X about it.

"Did you see the dentist today?"

"Yes, I did." He seemed to have a tinge of anger in his voice.

"Well, can he help you?"

"Oh, sure he can, but it's going to cost me 75 bucks! That's a lot of money for me. I'm not going to have it done!"

I was shocked – not that he didn't have "75 bucks" but that now, after 3½ months in the hospital at Medicare's expense, his response to spending his own money had been: That's a lot of money. I'm not going to do it!

That evening, to be certain of the public's share in this medical investment, I stopped in at the admitting office and checked on his bill – it was $275,000.

It needs to be said that, without doubt, Mr. X is a good man and a decent citizen. But he was now the victim of the Medicare "entitlement" system. Somehow, he had come to believe that "75 bucks" was "a lot of money" and that $275,000 just didn't matter, since it was someone else's money. This despite figures like the one cited in Martin Feldstein's column: Medicare health benefits for the aged will cost Americans $200 billion in 1996.

Do we really need Adam Smith to rise up and tell us again that the free market has an "invisible hand" that will control prices? Unfortunately, we probably do.

Under the promise of "entitlement," politicians actively protect the elderly from facing the dollar consequences of their demands. People believe they deserve all possible medical treatments, and they will not stop asking for them until they have to pay for them with their own money, even just a little bit.

Mr. Clinton used the terms "right to medical care" and "entitlement" quite freely during his campaign. Although such rhetoric may win elections, it is not healthy for our medical care crisis. It has made people feel justified in spending other people's money; they don't even ask about the price.

But the price is now hurting all of us. It's a lack of market forces that has caused our private medical insurance premiums to soar. It is also the reason that 37 million of our fellow citizens do not have medical insurance, and it is definitely the reason that our government has placed price controls on the medical profession and is threatening to place controls on the pharmaceutical industry and medical equipment manufacturers as well.

We will never satisfy the public's demand for something as valuable as medical care when it is offered "free" of charge. The message: We will control costs only when people have to pay an equitable amount for their medical care.

Mr. X didn't want his teeth fixed. It "cost too much." I wonder how much "unnecessary" care "costs too much" and might be eliminated if we brought the patient back into the marketplace.

When Mr. X was almost ready to go home, I knew he would be able to manage there with his wife, who was healthy, and his many friends. But he felt free to ask me one day about getting some help at home, to continue his recuperation. Maybe a physical therapist or a home nurse would be nice. I'm certain he felt entitled to them, though he didn't need them. But if I had said "no," I would have looked like a heartless, uncaring doctor. The system works that way, you know. I'm certain it would improve if I had the right to summon the Ultimate Cost Container and say, "I'll send them all out, but it will cost you $45 per visit."

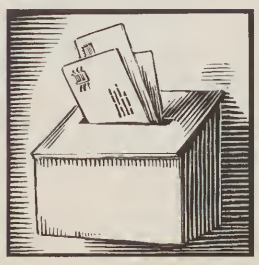
James P. Weaver, M.D., practices surgery in Durham, N.C.



"I'll have to give him kemosabetherapy.'

LETTERS

Thanks for 'Partners'



I am writing to express my thanks for the services of Dr. James Durham, a participant in the Illinois State Medical Society's "Partners for Health" program.

Dr. Durham recently served as a guest speaker for our bereavement support group. The doctor acquainted our members with the issues facing physicians in a small community and made practical suggestions about how [our members] might participate in taking control of their own health.

This program was both educational and informative, and our members responded with many positive comments about its importance and value. I believe that the doctor's presentation did much to promote better doctor-patient communication.

The doctor is to be commended for taking his valuable time to participate in programs such as these.

I cannot emphasize enough how vitally important these programs are to senior groups and organizations. It is only through education that organizations, groups and the public can become informed about how to maximize health care and medical services and utilize community network resources.

I highly commend ISMS for providing these educational programs to the public. The benefits are immeasurable.

– Janet Kay
Marion

The propriety of publishing disciplines

Your recent editorial commentary "Naming Names" is fraught with a propriety of righteousness – apparently self-serving in some sense, using the "professionalism" of it all as a basis. And who cares about Sidney Wolfe? Not me.

Why would I want to know about this or that health care provider who has been reprimanded due to an abridgment of the statutes of the Illinois Department of Professional Regulation? (I use the term health care provider, since not only MDs, but others involved in the care of the sick, could be just as involved.) Should I shun the offender? Should I jeer at him or her? Should I make snide remarks and embarrass the person?

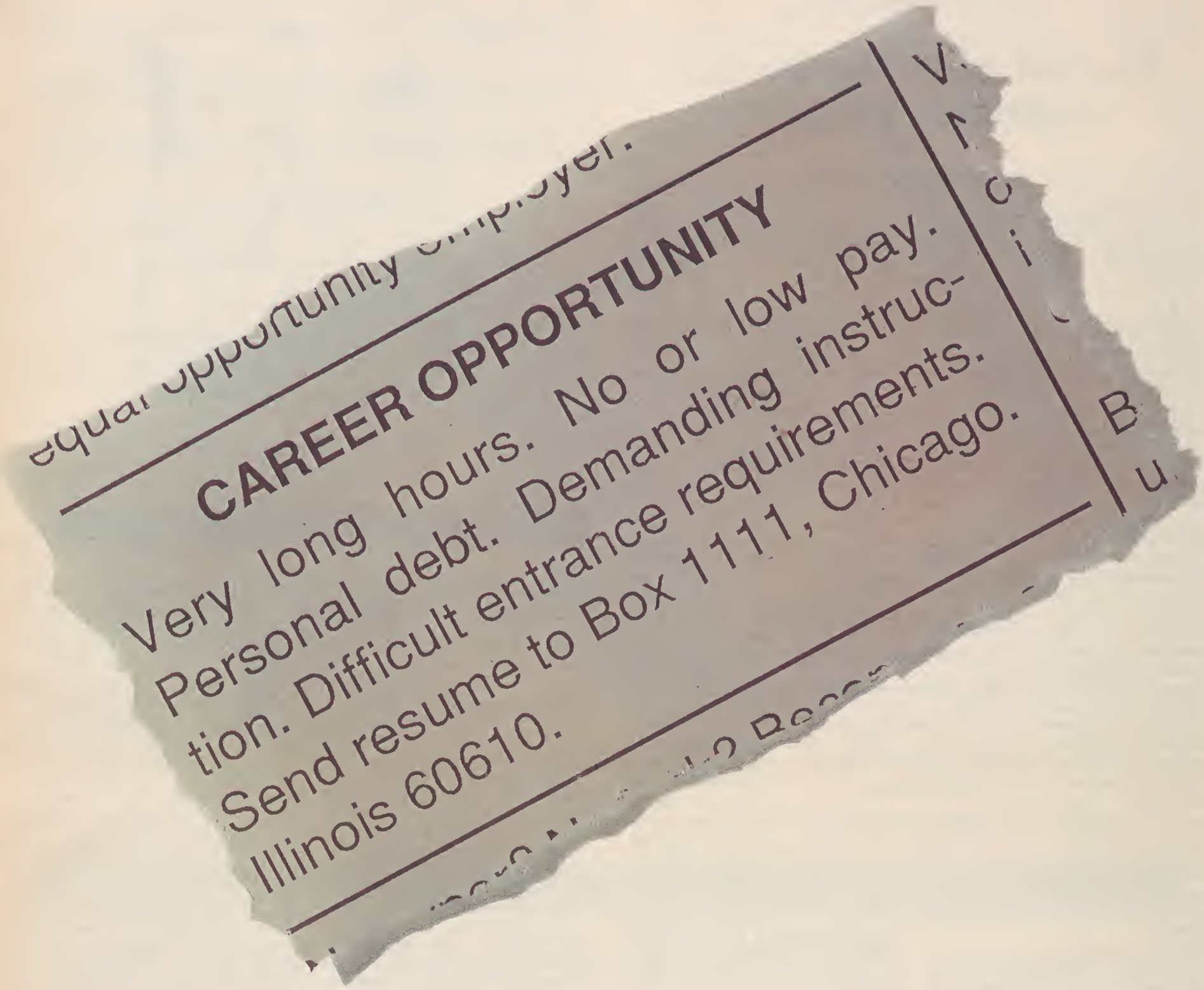
I have no axe to grind with any of the so-called professionals listed [as being] in violation. I do not recall any of their names among my acquaintances. One is in Washington, D.C.; another is in Georgia; still others practice hundreds of miles away from here.

It would seem more logical to me to suspend the license to practice "the Art" forever rather than trust that a reprimand or probationary period will correct the individual character flaw. Remember, the public – not the Illinois State Medical Society – suffers for these irregularities.

Finally, Samuel Johnson said, "A cucumber should be sliced, and dressed with pepper and vinegar, and then thrown out, as good for nothing." So be it.

– Richard W. Zalar, M.D.
Joliet

Illinois Medicine *welcomes letters on topics of interest to our readers. Write us at Letters to the Editor,* Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, Ill. 60602 or fax (312) 782-2023. Letters of any length will be considered for publication, but we reserve the right to edit for space.*



Med school wasn't for everyone.

You made the sacrifices. You wouldn't have done it if becoming a physician hadn't meant the world to you. It took a special person then. And it still does.

Being a physician isn't for everyone. Intelligence, dedication, and skill must coexist with sensitivity and compassion. At the Exchange, we understand the special demands placed on physicians, especially today. And for today's young physician, the Exchange begins at the beginning. By offering a substantial premium discount in the first three years of practice. It's what you would expect from the state's leading malpractice insurer. Because we're owned and managed by the physicians we insure.

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Case in Point explores closed reductions

PAGE 10

ISMIE Update

Malpractice Roundup

PAGE 11

Risk management watchword is support, not punishment

RISK MANAGEMENT: An effective risk management tool now includes physicians with open claims. By Kevin O'Brien

[CHICAGO] In its ongoing effort to minimize the likelihood that physicians will be sued, the Illinois State Medical Inter-Insurance Exchange has begun referring physicians with open claims to risk management education.

For the past several months, during the Physician Review Committee's review of open claims to recommend a course of action, the PRC has identified physicians who may benefit from the Exchange risk management educational program. The PRC's primary function is to decide whether to defend or settle a case.

For the past several years, physicians whose claims have been closed with indemnity have been referred to the program by one of the Exchange Physician Review and Evaluation Panels, which review the closed cases for underwriting reasons. Because the program has proved effective, the ISMIE Board of Governors decided in June to expand the program to include physicians on the "front end" of the process as well.

"A typical claim period can span seven or eight years from occurrence to disposition," said Phillip D. Boren, M.D., chairman of the Illinois State Medical Insurance Services Board of Directors. "The board felt that if the program could help a physician who has just been sued, it seemed a waste of valuable time to wait seven years before suggesting that he or she participate."

> *"Our only motivation is to help affected physicians as early in the process as possible."*
>
> **JERE E. FREIDHEIM, M.D.**

When physicians learn the PRC has referred them to the program, they may be understandably defensive, Dr. Boren said. "Coming on top of being named in a lawsuit, this action can only contribute to the stress the physician is feeling."

So Exchange officials emphasize that the referral is neither punitive nor used to build a case for surcharge or nonrenewal.

"Our only motivation is to help affected physicians as early in the process as possible," said Jere E. Freidheim, M.D., chairman of the Exchange Risk Management Committee. "The physician recommended for risk management education by the PRC is not being punished." Specific information about the physician's open claim is highly confidential, and only minimal generic information is shared with the Risk Management Committee.

THE EXCHANGE RISK MANAGEMENT educational program has three levels, and physicians may be referred to any or all three. The first level is the self-study program that new policyholders complete when they join the Exchange. It includes a handbook and videotape and stresses effective communication techniques between the physician and office staff and patients. It also explores documentation, confidentiality, informed consent, billing collection, patient selection and other risk management issues.

Physicians may also be required to attend one of the Exchange risk management seminars on such topics as effective physician-patient communication, incident and complaint handling, alleviation of the stress of litigation or general risk reduction. These seminars are offered throughout the year.

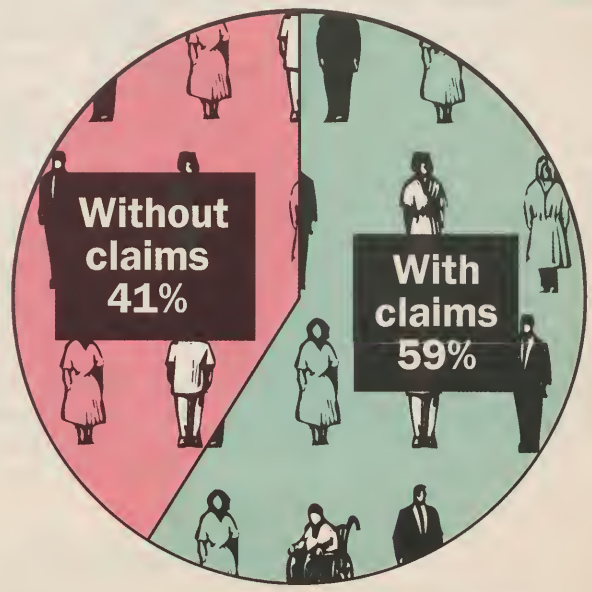
The third level of risk management training is the on-site office assessment conducted by a risk management committee member and Exchange staff. The on-site assessment includes a tour of the physician's office, interviews with the office staff and the physician, and a review of randomly selected charts.

Since the ISMIE board approved the program, the PRC has referred about 30 physicians with open claims for risk management education. ■



"I'd like to continue the triple bypass on your client, if you have no more objections, attorney Roberts."

Active ISMIE policyholders: Percent with, without claims*



*Active policyholders as of 6/30/92; includes corporations.
Data represents all claims regardless of outcome.
Source: Illinois State Medical Insurance Services.

Ending a doctor-patient relationship

MEDICAL LEGAL GUIDELINES

Editor's note: This is the first in a series of columns covering medical-legal issues. Written by the Illinois State Medical Society Council on Medical Legal Affairs, the information addresses legal concerns that physicians most commonly express to ISMS. The information is intended to serve only as a general guide for physicians, not as specific legal advice. Readers are advised to consult legal counsel regarding specific situations and questions.

According to guidelines from Morse, Giganti & Appleton dated April 1991, a physician may withdraw from a physician-patient relationship provided that the relationship is terminated in the proper manner, unless circumstances do not permit termination of the relationship. Abandonment is grounds for discipline under the Medical Practice Act of 1987. Once a relationship is created it may be ended in one of five ways without liability:

1) When medical care is no longer needed.

2) When the patient specifically withdraws from the relationship.

3) When the care of the patient is transferred to another physician. (It is recommended that the physician advise any successor physicians of the patient information necessary to continue treatment when this is known and upon request.)

4) When the physician who is withdrawing from treating the patient gives ample notice to the patient. (If the patient is without a current medical condition requiring care, the physician may simply notify the patient that he/she is withdrawing from the relationship and no longer wishes to provide care. If the patient has a continuing medical problem, the

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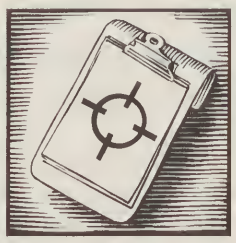
Case in Point

A regular feature using hypothetical case histories to illustrate loss-prevention maxims.

By Tony Sullivan

Case #1

Presenting complaint and initial diagnosis: A 26-year-old woman presented to a hospital emergency room complaining of pain in her lower left leg after falling on ice. A consulting orthopedic surgeon diagnosed a simple spiral fracture of the distal fibula.



The case in brief: The orthopedic surgeon placed the patient in a short-leg cast and discharged her on non-weight-bearing status with crutches. The patient saw the orthopedic surgeon about a week after discharge for a normal follow-up visit. She voiced no complaints, but the physician believed the cast was too tight, despite normal circulation and normal motor and sensory status. He applied a new short-leg cast to prevent problems. A week later, he replaced the cast with a short-leg walking cast and placed the patient on early weight-bearing status to promote healing and prevent atrophy.

One week later, the patient visited the hospital ER complaining of pain, swelling and other discomfort. The ER physician diagnosed superficial phlebitis and told the patient to visit her attending physician the next day. During that subsequent visit, the orthopedic surgeon reapplied the short-leg cast and returned the woman to non-weight-bearing status. He prescribed aspirin prophylactically as a precaution for deep vein thrombosis.

During the next month, the patient made two scheduled follow-up visits, during which the physician noted decreased pain and healing of the fracture.

Four months after the accident, the patient made an unscheduled visit to the physician, complaining of extreme swelling and pain. The physician prescribed medication to control inflammation. Three days later, the woman went to a hospital ER complaining of shortness of breath, rapid heartbeat and midsternal chest pain. She was admitted for suspected pulmonary embolism and treated with heparin. She improved clinically for the next 12 hours, then went into cardiorespiratory arrest and died. An autopsy revealed a large saddle embolism extending into the main left and right pulmonary arteries.

The resulting claim: The orthopedic surgeon was sued for failing to diagnose DVT, which resulted in pulmonary embolism and death.

The outcome of the claim: The claim was settled for $250,000.

Case #2

Presenting complaint and initial diagnosis: A 63-year-old woman went to a hospital ER complaining of pain in her right ankle. X-rays indicated a displaced, unstable bimalleolar fracture.

The case in brief: The attending orthopedic surgeon performed an open reduction and applied a short-leg cast, split to allow for swelling. A week later, the physician recast the leg in a short-leg nonwalking cast and discharged the patient. The incision and surrounding tissue enclosed in the cast were healthy at that time.

After a month, the physician removed the cast to examine the leg during a routine follow-up visit. He noted good alignment of the fracture but some skin breakdown at the suture line. Cultures indicated staph, and the physician prescribed an antibiotic and reapplied the cast. During two subsequent follow-up visits, the woman complained of increased pain, but the physician noted good alignment of the fracture with no swelling or fever, so he made no cast changes and continued antibiotic therapy. The next month, the patient went to a hospital ER complaining of lower-leg pain. The attending physician was out of town, so another physician saw the patient. When he removed the cast, a large amount of purulent fluid drained from many open wounds. An arteriogram revealed severe peripheral vascular disease, and a below-the-knee amputation was performed.

The resulting claim: The woman sued the attending physician for improper care and treatment of the fracture, which resulted in amputation of her lower right leg.

The outcome of the claim: The case was settled for $250,000.

The points these cases make: Physicians must strongly suspect problems whenever patients complain of discomfort, said Proctor R. Anderson, M.D., an orthopedic surgeon in Chicago.

Most complications in these cases result from improper monitoring, not improper casting, Dr. Anderson said. Lack of monitoring appears to have contributed to the adverse outcomes of both cases presented here.

A basic symptom physicians should monitor in casted patients is pain, said Richard A. Geline, M.D., a Chicago-area orthopedic surgeon and a member of the Illinois State Medical Inter-Insurance Exchange's Board of Governors and the Exchange Risk Management Committee. In Case No. 2, the patient complained of pain on several occasions, but the attending physician's responses appeared to be conservative. More-aggressive treatment, mainly more frequent cast changes and "windowing" the cast to monitor the skin breakdown at the suture line, may have been in order, Dr. Geline said.

In addition, physicians should be aggressive in asking patients about pain, according to risk management experts. Some patients may not mention it for a variety of reasons, such as embarassment.

But pain is a highly subjective symptom, added Dr. Geline, and physicians may find it difficult to decide how aggressively to address the symptom. He suggested, "If the pain pattern differs from what you normally expect, given the type and location of the fracture, remove the cast and assess the next move."

> *"You have to be aware of the whole picture and not just look at the x-ray to see if the bone is straight or crooked. The bone exists in a human being who has all kinds of needs that may or may not be influenced by the presence of that fracture."*
>
> **RICHARD A. GELINE, M.D.**

Another important condition to monitor in casted patients is deep vein thrombosis, added Dr. Anderson. DVT is a particularly dangerous complication in closed reduction cases, and it can be difficult to diagnose, he said. "There's no big red flag that's raised when a patient develops a DVT under a cast. About the only indication is low-grade fever." But if the cast is removed, several tests can identify a DVT or rule it out. Pushing on the calf to check for tenderness, which is the main clinical finding in a "cast clot," is the simplest test. More intense tests include venograms and Doppler studies.

(Continued on next page)

EXCHANGE Q & A



Q. How can I best protect myself from a malpractice claim?

A. Many claims can be prevented by paying close attention to some fundamental aspects of medical practice. The Exchange recommends taking these precautions:

- Become a good judge of character. Your knowledge of patients and their families can often forewarn you of potential claims.
- Recognize and report potential claims early.
- Answer questions from patients and their families truthfully and with conviction.
- Maintain detailed patient records. Never alter records, except in the acceptable way.
- Inform the patient of possible complications that could result from treatment.
- Provide ample information to avoid contributing to an unrealistic expectation of a perfect outcome.
- Request consultations when necessary.
- Develop a confident physician-patient relationship.
- Do not criticize prior treatments by other physicians.
- Use courtesy and good judgment.

Additional materials and programs are offered by the Exchange risk management department.

Q. How are premiums established?

A. The Exchange's philosophy is to charge each physician a fair premium, based on the risk that physician brings to the program. Annually, actuaries review loss data and recommend adjustments when indicated. Physicians approve the rates and any changes in classification, territory or underwriting.

Actuaries develop premium calculations based primarily on Illinois data, including such factors as loss history, classification and territory. National data are also considered.

Q. What should I know about general Exchange coverage?

A. The Exchange offers a sound "claims-made" program. Reporting endorsement (tail) coverage is offered to physicians who choose to leave the Exchange, and it is free to physicians who retire, are at least 55 years old and have been in the program for the previous five consecutive years. The Exchange also offers free tail coverage to the estate of a deceased physician and in cases of total, permanent disabilities that prevent the doctor from practicing medicine.

Prior Acts Coverage, as well as a discount program for groups of five or more physicians, is available. For individual physicians, there are four territories, nine classifications and multiple limits options. In addition, the Exchange's 1992 loss-free discount saved policyholders with no paid losses 3 percent to 10 percent. Premiums are due quarterly, and reduced premiums are available for newly practicing physicians.

Q. My family has expressed concern over my alcohol problem. I have heard about the Physician Assistance Program, but how can I get more information?

A. The Physician Assistance Program helps physicians cope with a variety of impairments, including alcohol and drug abuse, psychiatric disability, dual diagnosis, physical impairment, problems of aging, sexual misconduct and the stress of everyday medical practice. It is strictly an advocacy group and has no disciplinary authority. Also, all information about impaired physicians is kept strictly confidential.

For immediate crisis assistance, physicians may call the 24-hour Physician HELPline at (312) 580-2499. A physician will respond personally to all calls. For more information, call the Physician Assistance Program at (312) 782-1654 or (800) 782-ISMS. ■

Case in Point

(Continued from previous page)

Venograms are highly recommended in cases involving suspected DVT, but Doppler studies can be less conclusive, Dr. Anderson said.

Physicians should be alert for the development of DVT in all fracture cases and should take appropriate action if it occurs, said Dr. Anderson.

Treatment options for DVT include heparin or warfarin sodium therapy or nothing at all, Dr. Anderson noted. Many clots that develop under the cast go undiagnosed and resolve themselves. "The problem occurs in those few [clots] that do propagate up the leg and cause a pulmonary embolism.

"The question that often comes up is, Should you put somebody prophylactically on [warfarin sodium] or aspirin or something like that to prevent a DVT?" continued Dr. Anderson. "We do use prophylactic [warfarin sodium] after hip surgery or total knee replacement while patients are hospitalized and a few weeks after discharge, so they don't get a DVT. But I don't believe it is the standard of care to do that in an outpatient setting just because a patient has a cast on."

As illustrated in Case No. 2, reductions on older patients raise additional risk management issues. One issue is the potential for circulatory deficiencies, which casts can magnify. Physicians should always determine peripheral circulation, particularly in older patients, before performing reductions, Dr. Anderson said. In procedures involving the lower legs, physicians should make certain that both main pulses exist, especially if they are considering an open procedure.

If the patient doesn't have clearly indicated pulses, physicians should seek a vascular consultation, Dr. Anderson recommended. During the informed consent process, the patient should be notified of any risks, and discussion of those risks should be documented in the medical record.

Good communication with patients and their family members should continue throughout the course of treatment, said Dr. Geline. Patients should clearly understand the expected outcome of treatment. "Physicians need to address potential gains and risks with patients before, during and after treatment, so that no surprises occur. If a physician says nothing, the patient may expect one thing and get another. Then you've got a problem on your hands."

In addition to talking to patients, communicating with family members or others in the patient's support structure is also important, Dr. Geline added. Friends and relatives may need to play a larger role in helping patients perform basic activities such as walking, dressing and practicing personal hygiene. Explaining this beforehand can help prevent the unhappiness and tensions that might otherwise develop and be conveyed to the patient, eventually eroding a once-solid physician-patient relationship. And impairment of that relationship can lead to a potential lawsuit, said Dr. Geline.

"It's important to be aware of all the personal factors that surround the temporary inconvenience that occurs when you have a fracture," Dr. Geline added. "You have to be aware of the whole picture and not just look at the x-ray to see if the bone is straight or crooked. The bone exists in a human being who has all kinds of needs that may or may not be influenced by the presence of that fracture."

If patient pain is greater than what might normally be expected from a casted fracture, physicians are obligated to remove the cast and examine the leg, Dr. Anderson stressed. "You have to be suspicious." ■

Ending a doctor-patient relationship

(Continued from page 9)

physician must find a substitute physician/provider to provide care or provide sufficient written notification to the patient to allow the patient to find a substitute. The physician is responsible for care until a substitute is found. There are additional restrictions when a patient presents him/herself to an emergency room.)

"Sufficient notification" depends on the circumstances. If a patient has a continuing medical problem, it would not be unreasonable to expect the physician to continue treating the patient until substitute care is found, either by the patient or the physician. There is no definitive time period in which notification must be given.

5) When the physician is unable to provide care based upon the lack of training, experience, illness or incapacity. Any such illness or incapacity must be of a significant nature to disable the physician from being able to provide care.

The general guidelines for terminating a physician-patient relationship apply regardless of whether the physician will be paid for services. Thus, the same general guidelines pertaining to patient abandonment as discussed above apply when a physician is terminated from any state or federal program such as Medicaid and/or Medicare, a managed care program, or when a physician voluntarily withdraws from such a program. The physician should document the steps taken to terminate a physician-patient relationship in the patient's medical record.

A physician-patient relationship is established when a physician accepts or undertakes to render care to a patient. It is almost impossible to avoid creating a patient-physician relationship when a patient goes for a follow-up visit by way of referral from a hospital emergency room. It has been suggested that a release or a written acknowledgment may be used to create a temporary relationship. However, this may be risky and may ultimately leave the physician open to liability. A possibility which has been suggested is to create a limited physician-patient relationship which would cease after the follow-up visit, unless both the patient and the physician agreed to extend their relationship. ■

For more information, physicians may call ISMS medical-legal staff at (312) 782-1654 or (800) 782-ISMS.

MALPRACTICE ROUNDUP

Refusal to be transfused

A recent issue of *Hospital Risk Management* reports a case in which a patient sued a Florida hospital for obtaining a court order to transfuse her against her will. The patient, a Jehovah's Witness, left the hospital without the transfusion after the court order was obtained. She claimed she suffered additional injuries and emotional distress because the hospital violated her federal and state constitutional rights to privacy and freedom of religion. Her husband also claimed violation of his constitutional rights.

Florida's Supreme Court has outlined four provisions that allow the overriding of an individual's right to refuse medical treatment. These include the preservation of life, the protection of innocent third parties, the prevention of suicide and the maintenance of the medical profession's ethical integrity. The district court found that the plaintiffs suffered no injury from the hospital's obtaining the court order and that the hospital acted legally in informing her of its authority and intention to transfuse her despite her objections.

Finding that "there does not appear to be a true controversy present," the court dismissed the federal claims, leaving the emotional and physical injuries claim to be decided by a trial court. ■

Data bank offers free software

As reported in *Hospitals,* the National Practitioner Data Bank is offering software that allows hospitals to access the Data Bank by phone modem or diskette. The software and a user's manual are offered at no charge to eligible hospitals and other health care service providers required to query the Data Bank. The Data Bank has received more than 1,900 requests for the software.

Since the Data Bank opened in September 1990, about 1 million requests for information on practitioners have been submitted annually. With the current paper documentation system, processing requests takes an average of 26 working days, but electronic submission could reduce turnaround time to an average of three days, Data Bank officials said. ■

Hospital to pay $3 million for failing to perform transplant

A Pittsburgh hospital has been ordered to pay $3 million for missing two chances to perform a liver transplant on a patient with a malfunctioning liver. Doctors from the patient's health plan had referred him to the hospital, saying he would die without a transplant. According to testimony, two livers that matched his blood type were refused because the payment plan had not been worked out. The patient died before a third liver could be found. The jury ordered the hospital to pay $2.5 million in damages to the patient's wife and two daughters and $500,000 to his estate. ■

Exchange annual meeting scheduled, board nominations sought

The Illinois State Medical Inter-Insurance Exchange will hold its annual meeting on Wednesday, April 21, at 2 p.m. at the Oak Brook Hills Resort, in Oak Brook. At the meeting, seven members of the Exchange's Board of Governors will be elected by a majority of the members voting in person or by proxy.

The Board of Governors supervises the Exchange's finances and operations, and establishes all policies regarding its business and affairs. It normally meets four times during the year.

Throughout the nomination process, efforts are made to ensure a broad representation geographically, and by insurance class and specialty. All governors must be members of the Exchange.

Each board member is appointed to serve on at least one of the Exchange's five committees: the Nominating Committee, the Policyholder Services Committee, the Planning Committee, the Risk Management Committee or the Investment Committee. Each committee meets several times during the year and reports regularly to the board. Board members receive a stipend and are reimbursed for actual expenses incurred by attendance at Exchange board and committee meetings.

Any member of the Exchange interested in serving as a governor should write to Harold L. Jensen, M.D., chairman, Board of Governors, Illinois State Medical Inter-Insurance Exchange, 20 N. Michigan Ave., Suite 700, Chicago, Ill. 60602. A current curriculum vitae should be included. All letters of intent received at the Exchange office on or before Feb. 4 will be considered by the Nominating Committee. ■

MEDICAL T

Hospitals look for technology

With options ranging from laparoscopic equipme videophones, hospitals are

BY RI

Hospitals face enormous pressure today to keep up with the latest technologies. Some of that pressure comes from consumers inspired by media reports or personal accounts of a neighbor who underwent laparoscopic cholecystectomy and was up and around in two days.

Technology allows physicians and hospitals to provide better, quicker and less-invasive medical care, often in outpatient settings. Thanks to strides in imaging technology, for instance, exploratory surgery is rapidly becoming the "horse and buggy" of diagnostic techniques.

But the technology boom also fostered a "medical arms race" that has helped drive up health care costs, said Henry Alder, director of the Division of Clinical Services and Technology for the American Hospital Association. In a sense, hospital services in the '80s were analogous to the feeding frenzy of the stock market in the same decade, he said.

"Institutions were providing services to their community, but providing them from the standpoint of meeting the needs of medical staff," Alder said. "The ability to acquire these things has in a way outstripped [the hospitals'] ability to pay for them. In the past, decisions were made by fiat. Physicians needed this device and lobbied through politics within institutions. That was probably appropriate in the '80s."

In contrast, Alder said, hospitals in the '90s are changing from an "internal focus to an external focus," particularly in light of new Medicare regulations that could cut capital reimbursement for many institutions and the reality of managed care as the new gatekeeper. "[Hospitals] are going to make some tough decisions on what kind of technology they will provide. They will be bound to provide high-quality service in a cost-efficient manner, with adequate access to the community."

"If anything, we learned from the '80s that just because it's new doesn't mean it's better," said David Stulberg, M.D., an orthopedic surgeon and associate professor at Northwestern University Medical School. "If there's been an inclination of the hospitals, it's been to jump on things that are new just because they are new. That's been true in lasers and some imaging technologies. We have to be really clear about what our goals are.

"Depending on which side you're on, new technology can look like an expensive extravagance or a major breakthrough, and the answer is probably somewhere in between," noted Dr. Stulberg.

Within this shifting climate, formal technology assessment by committees made up of management, technologists and medical staff will likely increase as hospitals try to keep weeds out of the technology garden, said Fred Achilles, director of clinical engineering services for Rush-Presbyterian-St. Luke's Medical Center.

If technology is reined in, however, many health care professionals worry that a rare opportunity for the flagging U.S. economy might slip away. "If you look at our counterparts internationally, the industry we still lead is health care. We've had a system that has allowed us to be the leaders," said Douglas Dean, president and CEO of the 370-bed West Suburban Hospital Medical Center in Oak Park.

"The United States, for all its expensive medical care, has created an environment of leading technology development," agreed Dr. Stulberg. "We're in a great position to advance technology the fastest. We have to want to do it and figure out methods for doing it that don't break the bank."

Hospitals have adjusted to economic reality in some common ways. West Suburban, for instance, has a lease agreement to share two mobile MRI units with three other area hospitals – a radiology trend that is increasing across the nation, reducing both capital and operating costs. Alder added that cardiac catheterization labs and linear accelerators for radiation therapy are two more examples of collaboration among hospitals.

West Suburban also typifies the trend toward outpatient care and spending on outpatient technology, which will be its major capital investment in 1993. Dean projects that outpatient services will be 44 percent of the hospital's revenue base in 1993, up from 27 percent in 1991.

The hospital recently opened a freestanding imaging facility in nearby River Grove, a move Dean said was part of "unbundling" hospital services to transfer screens and tests outside the hospital. "We're trying to focus the hospital facility on acute care medicine," Dean said.

Despite seeming austerity, most U.S. hospitals increased their capital equipment budgets in 1992, according to a national



CHNOLOGY

that doesn't break the bank

to 'decision support' software to computerized
nited only by economics.

K ASA

survey by *Hospitals* magazine and the Linc Group Inc. of Chicago. The top reason cited was "remaining up-to-date."

The survey of 505 hospital CEOs found about one-third of hospitals expected to share equipment within the next year, and an average of 37 percent of a hospital's equipment budget is devoted to meeting outpatient demand.

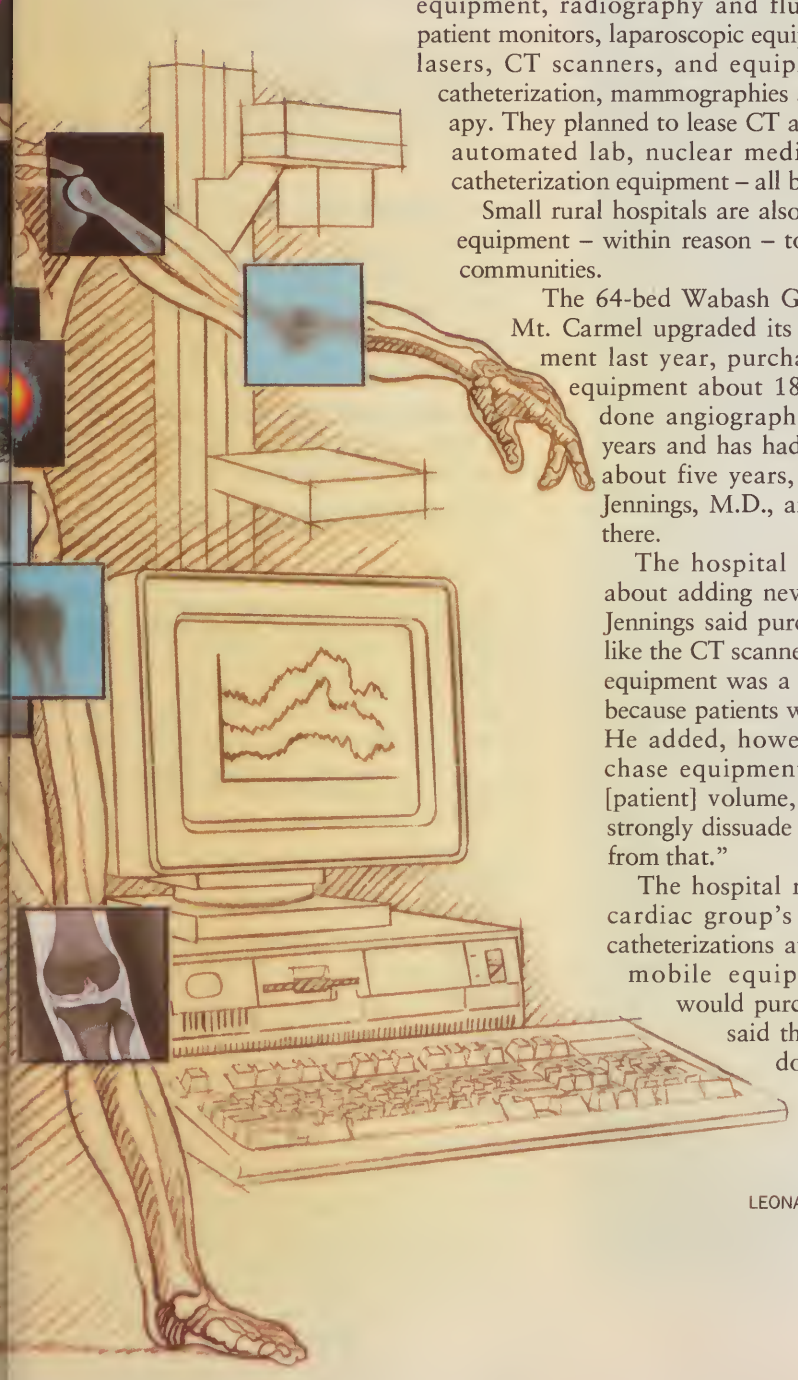
Hospitals surveyed planned to buy automated lab equipment, radiography and fluoroscopy rooms, patient monitors, laparoscopic equipment, ultrasound, lasers, CT scanners, and equipment for cardiac catheterization, mammographies and radiation therapy. They planned to lease CT and MRI units, and automated lab, nuclear medicine and cardiac catheterization equipment – all big-ticket items.

Small rural hospitals are also trying to upgrade equipment – within reason – to better serve their communities.

The 64-bed Wabash General Hospital in Mt. Carmel upgraded its ultrasound equipment last year, purchased laparoscopic equipment about 18 months ago, has done angiography for about three years and has had a CT scanner for about five years, said Lawrence P. Jennings, M.D., an internist on staff there.

The hospital remains cautious about adding new services, but Dr. Jennings said purchasing technology like the CT scanner and laparoscopic equipment was a matter of survival, because patients wanted the services. He added, however, "If you purchase equipment just to increase [patient] volume, it's asinine, and I strongly dissuade our administration from that."

The hospital recently rejected a cardiac group's offer to perform catheterizations at the hospital with mobile equipment the group would purchase. Dr. Jennings said the hospital and the doctors would have made money, but the service wasn't necessary because patients who need the procedure can go to Evansville, Ind., about 70 miles away.



LEONARD MORGAN

Some physicians watching technology in hospitals believe the real revolution is not in gadgets, but in computerization that will eventually encompass everything from billing to electronic, hand-held records containing up-to-the-minute information on each patient.

"The real key is going to be in the way patients are handled by the staff on the floors," said Achilles, "with the biggest innovation in nursing, where there will be more bedside monitoring and noninvasive techniques integrated with lab computers. It's just a matter of taking existing technology and integrating it."

The University of Health Sciences/The Chicago Medical School is piloting a notebook computer program at the Cook County Hospital emergency room. Third- and fourth-year students at UHS/CMS use powerful laptops and specially written software to prepare traditional patient workups electronically and then plug those into "decision support" software programs for differential diagnoses.

Northwestern University Medical School opened a 2,000-square-foot informatics training center in 1991 to train students, practicing physicians and faculty in state-of-the-art computerized decision making.

"A computer has inexhaustible memory and can do manipulations and calculations with extraordinary speed," said Michael Altman, M.D., associate dean for medical informatics and computer-assisted learning. "The physician has the intuition and sense. If you take away from the physician the need to remember everything and let him exercise the judgment side, you have the ideal combination.

"It seems low-tech in a sense, but this will be everyday and will affect everybody," he added. "It's going to affect the way every physician practices."

"There's too much emphasis on the gadget end of technology," added Greg Schmidt, M.D., an associate professor practicing in intensive care at the University of Chicago Hospitals. Dr. Schmidt is developing a computer education project that will enable physicians to use personal computers for up-to-date synopses on such topics as treatments and complications. The data base would be constantly updated.

"I think education is the way to improve patient

(Continued on page 14)

Hospitals look for technology that doesn't break the bank

(Continued from page 13)

care. Technology is not going to improve it in any substantial way. There's plenty that can be done to improve patient care that involves physicians' better understanding what we already know."

In the next several years, small rural hospitals could be rejuvenated by another technology that owes more to television than medical innovation.

Already, some medical centers in Texas and Georgia, supported by private financing and the state government, are experimenting with telemedicine, using high-tech digital video that enables a consulting specialist to examine a patient hundreds of miles away. The experiments have shown telemedicine can save the cost of a long trip to see the specialist and keeps paying patients at their local hospitals.

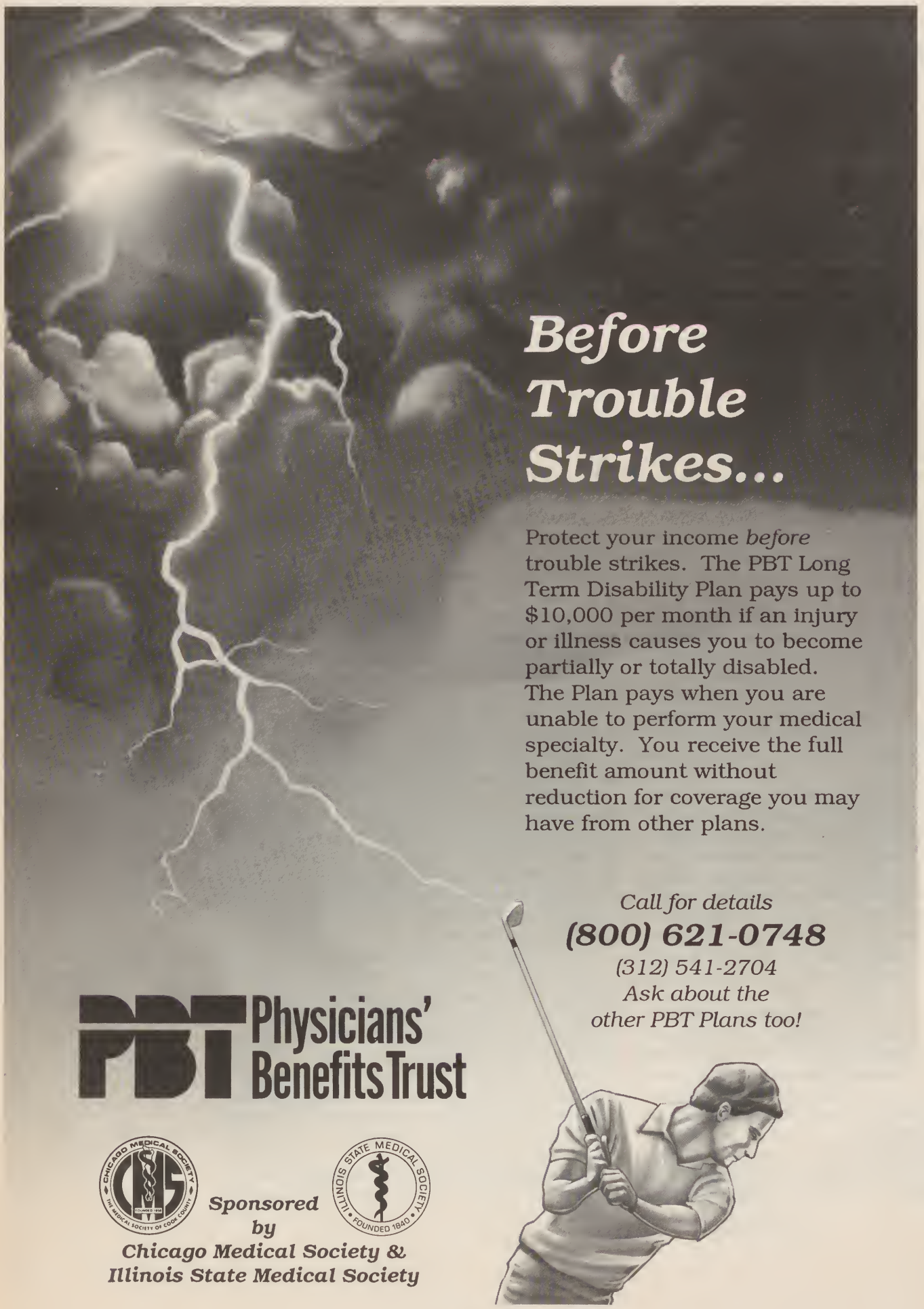
James Ausmann, M.D., head of the department of neurosurgery at the University of Illinois at Chicago, has a computerized videophone in his office that instantly transmits images of x-rays, angiograms and electronic scans. Radiologists have used the technology primarily at home in emergencies, Dr. Ausmann said, but today more physicians in all specialties are using it for long-distance consulting.

"I might say to another doctor, 'You don't need to do [this procedure].' The doctor saves time and money, and is given a diagnosis pretty quickly, and the patient stays home," Dr. Ausmann said. "I think this is going to be very common in hospitals. There are some scarce resources in medicine, and we have to find ways to integrate with rural family physicians."

Dr. Ausmann also has a bank of video equipment in his office in anticipation of a closed-circuit television network that will be connected to all UIC medical classrooms and has the potential to be projected by satellite anywhere in the world.

That would open up the operating room to experts worldwide, who could watch surgery in real time, consult or simply learn from colleagues on the scene.

With phone companies having already invested heavily in fiber optics, the seed for more sophisticated telemedicine may have been planted. ■



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EOE

Health care reform plan likely to focus on 'managed competition'

PROSPECT FOR CHANGE: The focus is on possible health care reform based on a plan introduced by the Conservative Democratic Forum. By Ginny Thiersch

[WASHINGTON] While he is likely to keep his campaign promise of introducing a plan for health care reform in the first 100 days of his administration, President-elect Bill Clinton may have to wait a year or more before reform is a reality, Congressional sources say.



In the meantime, increasing public, political and media attention has focused on legislation introduced in September by the Conservative Democratic Forum as a possible blueprint for the new administration's plan to increase access and control health care costs.

According to one analyst, the CDF plan uses the concept of "managed competition" to implement conservative mechanisms like marketplace incentives, to achieve liberal social goals like universal access to health care.

"The Managed Competition Act of 1992" establishes new state-level entities for health care providers and purchasers and sets up federal mechanisms to monitor outcomes and control health care costs. The program's premise is that by providing incentives to the health care market to hold down costs through more efficient performance, hands-on government control of health care can be avoided.

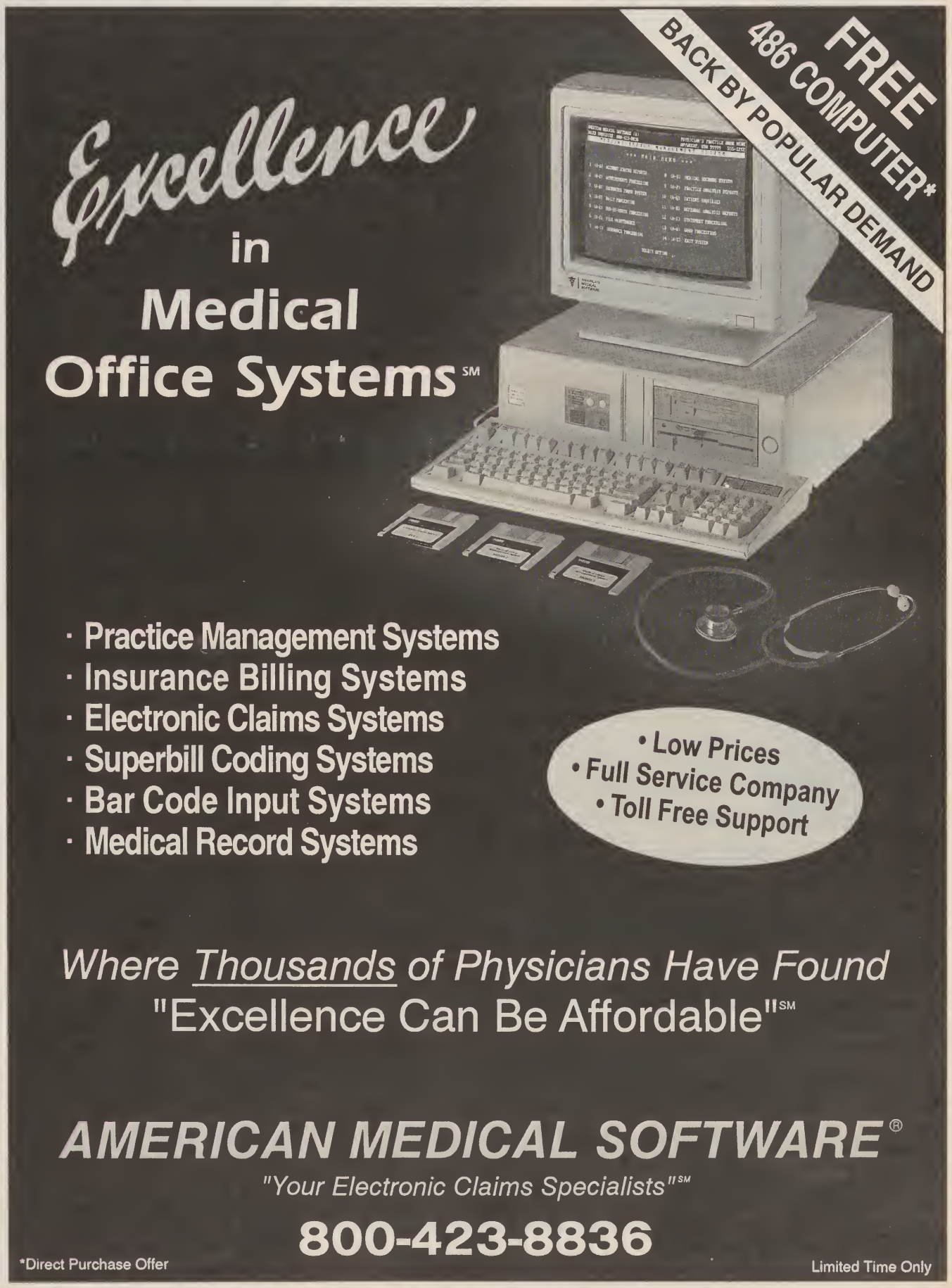
Increasing public, political and media attention has focused on legislation introduced by the Conservative Democratic Forum as a possible blueprint for the new administration's plan to increase access and control health care costs.

THE CDF PROPOSAL BEGINS with changes to the tax code to encourage insurance companies and health care providers like hospitals and physicians to form Accountable Health Plans – improved and expanded versions of today's managed care groups, like PPOs and HMOs. Key provisions of the care offered by AHPs are required patient copayments for all but preventive care; insurance reform, including community rating and the elimination of pre-existing condition limitations; and exemption from (or elimination of) almost all state insurance law. AHPs would be required to provide covered health care services through the establishment of what the bill calls a "comprehensive network of providers."

While AHPs address the provider side of the health care equation, new group purchasing entities would be established for health care consumers. Nonprofit Health Plan Purchasing Cooperatives would be established in each state, and all citizens in the state working for companies with less than 1,001 employees would join an HPPC to obtain health care insurance. By grouping medium and small companies and the self-employed into these "cooperatives," economies of scale would allow small employers to more easily provide health care coverage for their employees. Unlike earlier "pay or play" proposals, the CDF plan doesn't mandate that employers subsidize health care coverage.

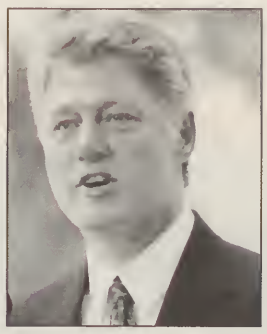
The state-chartered HPPCs would give employee/members a choice of AHPs, all of which would compete on equal ground and would offer the same package of basic benefits and assure coverage to all employees, regardless of health status, at community-based rates. Competition would be based on price and service. It is this "managed competition" that plan supporters point to as a means of reducing the annual increase in health care spending – by forcing the provider networks to compete for business, the CDF anticipates costs will come down. The HPPC would collect premiums and pay the AHP; the responsibility of benefits continuation under the Consolidated

(Continued on page 21)



Mystery Santas unmasked ... How well did you do?

The Dec. 18 issue included a contest to guess the identities of eight "Santa-cized" people who were quoted in *Illinois Medicine* during 1992. Finally the moment of truth has arrived: Our Santas have been unbearded and are identified on this page.

#1: President-elect Bill Clinton




#2: Chicago trial lawyer Philip H. Corboy




#3: Bush health adviser Gail Wilensky, Ph.D.




#4: Guest Editorial author Quentin Young, M.D.




#5: Former Senate hopeful Rich Williamson




#6: U.S. Rep. Dan Rostenkowski




#7: Illinois Secretary of State George Ryan




#8: The anonymous "Detail Man"

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The prescription for noncompliance

PATIENT COMPLIANCE: Following doctor's orders requires communication and documentation.
By Janice Rosenberg

[CHICAGO] In an ideal world, patients would follow their physicians' orders to the letter. But in reality, noncompliance is often an issue between physician and patient. Communicating openly with patients and carefully documenting those conversations – and the results – can improve patient compliance while ensuring proper risk management.



KATHERINE STREETER

Patients fail to comply with physicians' orders for many reasons. Sometimes they simply don't understand what their physicians expect them to do. In such cases, improved physician-patient communication can make a big difference.

"Tell patients what's going to happen and what the risks are," advised Fred Z. White, M.D., a member of the Illinois State Medical Inter-Insurance Exchange's Risk Management Committee. "Tell them why you want them to do what you want them to do. Usually when patients understand, they are much more compliant."

Lawrence P. Jennings, M.D., an internist in Mt. Carmel, has observed that compliance improves when physicians have the time to talk with patients and involve them in treatment. "I tell patients which drug I prefer; then I give them some options and tell them to pick the drug they can live with best," he said. "My hope is that if they're involved in the decision, they'll continue to take the medicine."

Communicating openly with patients and carefully documenting those conversations – and the results – can improve patient compliance while ensuring proper risk management.

Even when physicians explain a medication's purpose, directions for taking it and possible side effects, other circumstances can cause noncompliance. For example, patients may find they can't afford to fill their prescriptions.

"If you write five or six prescriptions for a patient, and the person sees the expense involved, he or she may try to pick and choose which is the most important," said Edward J. Fesco, M.D., a surgeon in LaSalle and a member of the Exchange Risk Management Committee.

TO PROMOTE COMPLIANCE physicians should present patients with the most economical alternative, according to Dr. Jennings, whether that means appealing to drug representatives for samples or prescribing generics.

"I recently had a patient admitted to the hospital for congestive heart failure because he couldn't afford to buy [medication]," Dr. Jennings said. "Patients cost the whole health care system a lot of money when that happens."

Even after patients have filled their prescriptions, other factors may lead to noncompliance. Perhaps a friend tells the patient that the medicine didn't work for her. Or the patient may start the medicine, feel better after a few days and fail to complete the course. Maybe the patient finds the side effects are too debilitating.

Occasionally, noncompliant elderly patients are in the early stages of Alzheimer's disease or other mental disorders. They may be unaware that they are failing to comply. In such cases, physicians should arrange for someone else to take charge of the patient's medication.

Why do some patients remain consistently noncompliant despite physicians' best efforts? Some are skeptical about drugs in general. Others don't share the physician's commitment to their own treatment.

"Some feel that strong individuals shouldn't need to take medications," said Dr. Jennings. "Others think they'll miss just one dose, but then they fall out of the habit, and pretty soon they're not taking the medication at all."

Physicians should document all cases of noncompliance, including missed appointments, misuse of prescriptions, and evidence of smoking or drinking despite the physician's advice to quit. According to Timothy Nickles, a partner at the law firm of Wildman, Harrold, Allen & Dixon, in Chicago, documentation is essential in risk management. He emphasized the importance of recording the facts of noncompliance – not the physician's conclusion that noncompliance has occurred.

"Be as detailed as you can," Nickles told *Illinois Medicine*. "Be specific about what the patient is doing. If you told him not to put any weight on the cast on his foot, and his mother says he has been running on it, write exactly that in his record. Focus on a dispassionate recording of noncompliance."

In Illinois, medical records are admissible as evidence in court. According to Nickles, when a physician's record documents the necessary information in a clear, simple and straightforward way, the record is the best witness.

In particularly persistent noncompliance cases, a physician may wish to terminate the patient's care. "Before you fire a patient, inform him or her of the risks [of noncompliance] and put that in the record," said Dr. White. "State what you've advised the patient to do and that the patient is aware of the risks involved in not doing it."

IF THE TIME COMES TO terminate care, a physician should ascertain that the patient is not acutely ill.

"Then, send a letter stating the reason for the termination," said Nickles. "State that it will go into effect in 30 days. Include the recommendation of a new physician, or the name of a referral service or medical society that will help the patient find a new physician."

The letter should be sent by registered mail with a request for a return receipt. Nickles also strongly recommends that the physician make a follow-up telephone call to be certain the patient has received the letter. All these efforts must be appropriately documented in the patient's record.

No physician is happy about terminating a patient's care. When Dr. Jennings has noncompliant patients, he makes every effort to work with them. "After two or three noncompliant issues, I set aside a whole office visit to go over the treatment. I stress the importance of the regimen and go over what they're taking and why, and the options."

Dr. Fesco handles potential noncompliance in a similar hands-on way. "If patients are taking three or four different [prescriptions] over a period of years, I have them bring in [the medications] now and then, show them to me, and tell me how they're taking them. I want to be sure they are taking them correctly."

Both Dr. Jennings and Dr. Fesco document such patient meetings in the patient's chart. They list all medications the patient is taking and note that these medications have been discussed.

Helping patients comply takes time and attention. "We sometimes try to get through a busy day and get everyone seen and taken care of, and we don't really spend as much time as we'd like," said Dr. Jennings. "To ensure compliance, we need to become co-partners with our patients and include them in the decision-making process." ■

IDPR DISCIPLINES

September 1992

Noemi A/K/A Naemi Borrillo, Niles – physician and surgeon license reprimanded and fined $2,000 for alleged unprofessional conduct.

Gina Marie Dieudonne, Chicago – physician and surgeon license placed on indefinite probation after failing to repay Health Education Assistance Loans.

Elise Moss Neeld, Grand Forks, ND – physician and surgeon license placed on indefinite probation after being disciplined by the State of Minnesota.

Lorraine Nessler, Chicago – physician and surgeon license reprimanded for prescribing controlled substances while her controlled substance license was nonrenewed.

Donald William Zeilenga, Longview, WA – physician and surgeon license placed on indefinite probation after being disciplined in the State of Washington for unprofessional conduct.

October 1992

Victor Canelas, Elmhurst – physician and surgeon license revoked after negligence in prescribing drugs.

Marion Dorn, Eldorado – physician and surgeon license issued and placed on indefinite probation for answering affirmatively to personal history questions on his application.

Immanuel L. Gandoinco, Center Ridge, New York, NY – physician and surgeon license indefinitely suspended after being disciplined in the State of New York for gross negligence and incompetence.

Eugene Landrum, Bloomington– controlled substance license previous probation extended to August 1995 after violating probation with the Department.

Morton Miller, Skokie – physician and surgeon license placed on indefinite probation and fined $20,000 and controlled substance license indefinitely suspended after prescribing non-therapeutic controlled substances.

John P. Pope, Benton – physician and surgeon license and controlled substance license indefinitely suspended after allegedly violating the Medical Practice Act.

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

Employee of the Month 'works hard to satisfy doctors'

[CHICAGO] On Dec. 11, exactly three years to the day after beginning employment with the Illinois State Medical Society, underwriting secretary Julie Latoza was named Employee of the Month. She received a plaque and a check for $200 at an award ceremony held at ISMS headquarters in Chicago.

Latoza is responsible for screening all correspondence, including premium checks. Her biggest responsibility, she said, is processing loss history requests from physicians, hospitals, HMOs, PPOs and other agencies.

"Those who work with Julie appreciate greatly her dedication and willingness to do what needs to be done," said Illinois State Medical Insurance Services Underwriting Vice President Al Allphin, presenting the award. "Julie works hard to satisfy doctors. She does a heck of a job."

Donald A. Udstuen, ISMIS Chief Operating Officer, extended his congratulations to Latoza, and added, "Julie has been tested under fire. She's done an outstanding job in the underwriting service circle and in a presentation for the Steering Committee." Both division service circles and the insurance Steering Committee were formed last year as part of the new "Physician First Service" initiative.

"I'm really honored," Latoza said accepting the award. "I work with a lot of nice people, which makes the environment much easier to work in."

All permanent, full-time ISMS and ISMIS employees – except senior management – are eligible for the Employee of the Month award. To nominate a staff member, contact the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■



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Julie Latoza was named ISMS' Employee of the Month for December.

YOCON®
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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

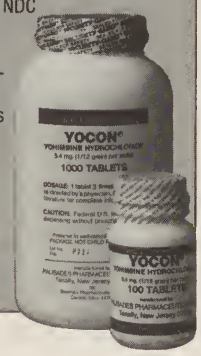
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Reform task force

(Continued from page 3)

propose similar taxes in his fiscal 1993 budget, they failed during the past legislative session.

One group member suggested the assessment program be expanded to tax other health care providers such as physicians. This idea was dismissed by the task force after Public Aid Director Phil Bradley explained that monies collected through the assessment plan are funneled into dedicated funds, meaning hospitals and nursing homes would not benefit from this additional "physician revenue;" the funds would be eligible for distribution only within the physician budget line.

In written comments submitted to the task force, the Illinois State Medical Society reinforced its opposition to extending the assessment program to other providers. "Given the lack of attractive choices, ISMS recognizes the need for the current Illinois institutional assessment programs or some modification of them," wrote ISMS Chairman of the Board of Trustees Jere E. Freidheim, M.D. "As has been demonstrated, institutional providers have historically been paid a greater percentage of their charges than have practitioners. Unlike hospitals and nursing homes, physicians did not elect to participate when the assessment program provided federal money with no strings. Given the newly adopted controls, this position is even more appropriate now."

Despite the task force members' varying opinions on how to fund Medicaid in Illinois, their recommendations must be on the governor's desk by Feb. 1. To facilitate the development of the actual document, Wish named a working group representative of the full 36-member task force. ISMS Executive Vice President Alexander R. Lerner was one of nine task force members appointed to the subcommittee.

The working group, which held its first meeting Dec. 22 in Chicago, will submit draft recommendations for discussion at the task force's final meeting Jan. 19.

While acknowledging that the working group members participated in a "spirited exchange of views" during the three-hour meeting, Bradley said there is a "general recognition of the magnitude of the assessment [problem]." The program accounts for one-third of the entire public aid budget, or $1.5 billion, he said. "Everyone involved with the task force now understands the catastrophic effect on the Illinois health care system if that amount of funding would be eliminated," Bradley noted. "The group is exploring other options, but because of [the program's] size, it's hard to envision a substitute." ■

Hearings

(Continued from page 3)

the Medicaid assessment program should continue. "We are there as good access to care. ... Without this tax support, we would not remain in business. If you were to take this tax away, St. Elizabeth's Hospital would lose $5.5 million next year."

But not all hospitals around the state support the assessment program. Representatives from those institutions told the task force another, more fair, way of financing the state's Medicaid system must be found. The Illinois hospital community is split over this issue: Some struggling inner-city and small rural hospitals with high Medicaid payer mixes would be forced to close their doors without the assessment program, and suburban institutions with solid bottom lines don't want to continue paying assessments that eat into their profits.

WHEN THE GOVERNOR ANNOUNCED the assessment program last May, he said those hospitals paying more than they get back from the plan could afford to absorb the "losses" without passing those costs along to private pay patients. But instead hospitals chose not to absorb those losses and are passing the costs on. According to Illinois Hospital Association testimony, on average, insured hospital patients are picking up $900 in shifted costs per hospital stay.

Some task force members harshly questioned the representative from Community Hospitals Alliance for the Medically Poor, a 14-hospital coalition of mainly suburban hospitals that "lose" under the current assessment plan. None of the 14 hospitals operates in the red, and Ken Bauer, chief executive officer of CHAMP member Hinsdale Hospital, told the task force that his institution sees annual profits "in the neighborhood of $8 million to $10 million" a year. Hinsdale Hospital pays about $3.4 million into the assessment program and receives about $2.6 million for the 5 percent of its annual patient load on Medicaid. "So in essence, we are paying the state roughly $600,000 to $800,000 [a year] for the privilege of providing care for quite a number of Medicaid patients," Bauer said. ■

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General surgeon needed to join established solo practice in western suburbs of Chicago. On staff at three hospitals. Very active at Level II trauma center. Contact Sara Fredrickson, M.D., 501 Thornhill Drive, Carol Stream, IL 60188; (708) 510-9949 or fax CV to (708) 510-0235.

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AIR FORCE

CIMRO wins Medicaid review contract

(Continued from page 1)

said. "We believe hassles impede access to care," Gagliardo told *Illinois Medicine*. "We won't give [physicians] the hassle factor on minor problems. [Ours is] a much more medically reasonable approach."

HISTORICALLY, ABOUT 90 PERCENT of identified quality issues are rated severity Level I, Gagliardo explained, meaning they are "minor, almost nitpicky issues." Under CIMRO's review program, these cases will not go on for further review; instead they will be profiled in the aggregate and used for educational purposes, she noted. If CIMRO does uncover a quality problem, the case is referred to IDPA's existing quality review structure, the Medicaid Quality Review Committee.

"This will allow us to focus our resources on quality issues of significance," Gagliardo said. "Physicians really get angry with Level I [citations]. It might have been a very difficult case, and no one congratulated the doctor for treating the patient well; [the review organization] is only criticizing some minor aspect of the case. You don't want to expend a lot of resources on a minor issue, such as documentation. But if there's a pattern, you do want to address that and educate the physician."

CIMRO also will eliminate "inflammatory" language used in its reviews, she said. "The 'gross and flagrant' wording will not be used," Gagliardo said. "It's not necessary to use inflammatory language that sounds like [an accusation of] malpractice."

> *"We believe hassles impede access to care. We won't give [physicians] the hassle factor on minor problems. [Ours is] a much more medically reasonable approach."*
>
> **MARYLYN GAGLIARDO**
> **CIMRO CEO**

Representation and involvement from physicians in all corners of the state is "essential," Gagliardo said. "The only way to have a credible and objective peer review program is to have a broad base of actively practicing physicians."

CIMRO will implement what it calls a "true peer review match," she noted, explaining that physicians of like specialty, practice setting and geographic region will perform the reviews. So physicians in Cook County will be reviewed by other doctors in the county, and in smaller rural and urban downstate communities physicians will be reviewed by doctors who practice in similar hospital settings. "Physicians on staff of a hospital won't do the review [for staff at that same hospital] because it would be a conflict," she said. "But the reviewers will be within the same geographic area."

Physician review will occur "at all levels, from the start" of the process, Gagliardo noted. "We will have enough layers [of review] for due process, but not so much that the review is not timely," she added.

Currently, CIMRO has 1,200 physician members throughout central and downstate Illinois. Gagliardo expects that number to balloon when physicians from Cook County and other northern communities join. Within the next few weeks, CIMRO will be restructuring its board to reflect statewide representation.

"The board needs to be representative of the physicians within each of the regions [southern, central and northern Illinois and Cook County]," she said. Dr. Kolb added that the Chicago Medical Society, which, with the Illinois State Medical Society, supported CIMRO's application, "will be an integral part of our organization." He said CMS will have at least one representative on the CIMRO executive committee and board of trustees.

Based in Champaign, CIMRO also will operate two satellite offices in LaGrange and Belleville. About 75 percent of the total review volume is expected to come from Cook County, Gagliardo said. In December, CIMRO sent letters to all Illinois county medical societies asking for assistance in securing reviewers from all areas of the state to ensure local peer review, she said. Physicians wishing to join CIMRO and serve as reviewers may call (800) 635-9407 to request an application or additional information. ■

Medical-legal issues

(Continued from page 1)

The ISMS Medical Legal Council focuses its energies on legal developments that affect the medical profession.

Last year the Medical Legal Council developed "A Physician's Guide to Advance Directives," a comprehensive collection of background information to educate and assist physicians in helping their patients manage these issues and make important decisions. The "Physician's Guide" complements the patient brochure "A Personal Decision," which discusses – from the patient point of view – living wills, power of attorney for health care and organ donation. The booklet contains the legal forms necessary for patients to complete these advance directives; the physician's guide includes additional legal background to help physicians discuss these issues with their patients.

The Medical Legal Council maintains a critical liaison with the Illinois State Bar Association. It oversees the Impartial Medical Evaluation Program, through which the Society responds to requests from the Illinois Industrial Commission and circuit courts for physician members to provide examinations of and reports on contested medical cases.

Because of the special nature of the physician-patient relationship and because the areas considered by the council are so sensitive, medicolegal information provided by the council should not be considered legal advice.

The council notes that most medicolegal questions can be grouped into one of three categories:

In the first, the physician raises a question that is specific or unique to the individual practice or person. A question regarding incorporation of the practice is an example of this type of question. In such instances, physicians are advised to consult with their own attorneys.

The second category of questions covers specific Illinois statutes or regulations regarding the practice of medicine in the state. This category covers a wide variety of topics, from the corporate practice of medicine to fraud and abuse. In most cases the council can appropriately respond to these queries by citing the appropriate statute or regulation, most of which can stand alone for interpretation.

The third category of queries will be covered in the new medicolegal column: questions that can be answered only by some interpretive opinion of Illinois law and regulations in general.

The council emphasizes that while broad-based general interpretations can be useful, physicians who wish to apply the information to specific situations in their practices should consult further with appropriate legal counsel. ■

Editor's Note: The new medical-legal column begins on page 9.

'Managed competition'

(Continued from page 15)

Omnibus Budget Reconciliation Act of 1985 would be assumed by the HPPC. Very large employers, those with more than 1,001 employees, might form their own AHPs.

The CDF proposal eliminates Medicaid, providing instead government subsidies so that unemployed and low-income individuals could also purchase insurance through HPPCs. The new federal program would be means-tested, and a sliding-scale fee would be established for people at or minimally above the poverty line. State funds previously directed to Medicaid would be used to help finance long-term care.

Prevention is cited as a key to controlling health care costs in the CDF proposal: Preventive services covered under Medicare would be expanded, and no patient copayments or deductibles could be charged for preventive care.

Malpractice reform is also included in the CDF plan. Limits on noneconomic damages (the figure $250,000 is cited in the CDF legislation) and a reduced statute of limitations are called for.

A National Health Board is proposed in the CDF legislation. The NHB, which would replace the U.S. Health Care Financing Administration, would define the standard minimum health care benefits package all AHPs would be required to offer, and would establish price and health outcome reporting mechanisms, including number, cost and results of each procedure performed.

The bill's sponsors anticipate that by eliminating the cap on Medicare health insurance taxable income, capping health insurance premium deductibility and redirecting Medicaid spending, any increased federal costs associated with this proposal would be covered.

Supporters of the plan point out the degree of freedom left to the individual states to customize the plan to meet each state's needs. Critics point out that HMOs, a concept that has been in place for almost 20 years, have yet to produce more than modest benefits, and the gatekeeper concept central to holding down health care costs in HMOs has been criticized in the past. ■

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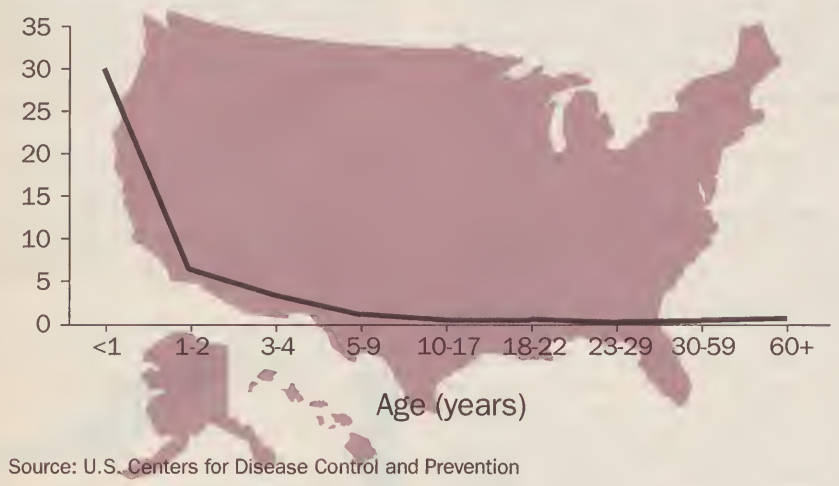
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Our Lady of the Resurrection Medical Center

Incidence of meningococcal disease in the United States by age group



Source: U.S. Centers for Disease Control and Prevention

Meningitis vaccination efforts continue at U of I

(Continued from page 2)

wouldn't have needed to vaccinate," she said.

Dr. Jackson denied that there is necessarily a link between college life and meningitis, but suggested Illinois' episode could be similar to cases of meningitis found among military recruits. In the military, recruits receive immunizations against meningococcal disease, she said. A reason for this is the stress of military life; stress can be a factor in susceptibility to meningitis. "College may be like that too," she said.

Half of all meningitis cases occur in children under age two, Dr. Jackson noted. Even so, given the number of cases at the university, the CDC felt students were at elevated risk and should be vaccinated. However, Rowan stressed that students are at very low risk even with the elevated levels.

When the first two deaths occurred in 1991, panic spread quickly across the campus, and 7,000 students were consequently given the prophylactic antibiotic rifampin. The measure far exceeded CDC recommendations to provide the drug to the victims' contacts, but Rowan said the university's main concern was dispelling students' fears and the anxiety of their parents.

In a three-day mass vaccination at the university's armory in February 1992, meningitis vaccine was offered free of charge to undergraduates, and parents were contacted about having their children immunized.

"I know a lot of people felt threatened,

Meningococcal disease hits Univ. of Iowa

CAMPUS OUTBREAK: Another Big 10 university seeks help from Illinois in combating the disease and dispelling student fears. By Anna Brown

[IOWA CITY, IOWA] The University of Iowa at Iowa City recently announced two cases of meningococcal disease on campus, and two others were diagnosed in the community, according to campus officials. The outbreak is similar to the eight cases that have developed among the student population at the University of Illinois since February 1991.

"Our student health service has been in contact with its counterpart at the University of Illinois," said Joanne Fritz, director of university relations. "We've taken a proactive approach, offering the vaccine to regular students."

During a five-day clinic, the university vaccinated free of charge 18,000 students, Fritz said. "We sent out letters to parents and students and got a good response. We are still urging students to get vaccinated, but now they will be charged," she said.

"One thing we learned from Illinois is that we needed to move quickly toward prevention," Fritz explained. "They had mentioned that they didn't have a good response until they contacted parents. We contacted parents up front and had a great response."

Fritz said there was no way of knowing whether the Iowa cases were connected with those at Illinois, but she said, "There is considerable visiting back and forth" between the two campuses. In fact, the two Iowa students who contracted the disease attended a football game at Illinois in October, she said, adding that health officials can't be sure of the connection. ■

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but I wasn't that worried," said Mary Burke, a junior from Western Springs, inoculated in February. "I didn't think I had come in contact with anyone who had meningitis; they weren't in any of my classes. I felt that it wouldn't happen to me."

Jason Brown, a senior from Sycamore, said he did not feel threatened either. He is among a minority of undergraduates who were not immunized. Last spring, Brown lived at the Illinois Street Residence Halls, where Troupe had also resided.

Brown said he learned about the vaccination program through campus fliers and in class. "The subject is basically dead on campus," he said. But the university will continue to send out information about meningitis along with general information at the beginning of each semester, Rowan said.

A letter to parents in June 1992 asked for help in vaccinating remaining students who had not been immunized. The letter, signed by Stanley R. Levy, vice chancellor for student affairs, urged parents to ascertain whether their children had been immunized and to discuss the vaccine with them. Levy described the vaccine used as a "polysaccharide vaccine, which cannot cause the disease it is designed to prevent." All prophylactic measures were funded entirely by the university.

Dr. Jackson commended the university for being "very professional and concerned" about quickly handling the outbreak and seeking expert opinion. ■

Prescription program

(Continued from page 4)

and time-consuming, according to DASA. The new 6-month pilot program, slated to start Jan. 1, will test the feasibility of having pharmacies send the department copies of prescriptions through electronic data transfer. Osco, Walgreens and Baxter Healthcare pharmacies will participate in the computer transmission test of "trip script" forms.

Because the Controlled Substances Act calls for the department to receive the third copy of the form, the pilot will be implemented as a "parallel" program, Long said. The participating pharmacies will submit the information electronically and mail the actual copies to the department. This will enable DASA to ascertain whether the pilot project allows for collection of the same information and generation of similar reports as under the manual system. The first data transfer will occur Feb. 15.

"The triplicate program is a good program, and we're trying to make it a better program by cutting costs and continuing to provide needed services," Long said. "If we can operate a program that will get us the same information and in so doing cut administrative costs and hold down the costs of the [physicians] and pharmacies, it's a win-win situation.

"We hope and project a successful pilot program will make for better and more timely reporting and keep the costs down so we won't have to raise costs to physicians," Long told *Illinois Medicine*.

If this program is as cost-effective as the department projects, he said, "inflation would have to go absolutely bonkers for us to raise the price" of triplicate prescriptions. ■

IDPA raises physician reimbursement rates

(Continued from page 1)

successful in guaranteeing access to health care for Medicaid recipients unless we can rely on the services of the state's physicians."

The rate hike, part of the new IDPA Healthy Moms/Healthy Kids managed care initiative, is the first step in trying to recruit more Illinois doctors to participate in the state's Medicaid program, Bradley said. IDPA acknowledges there has been "some" physician attrition caused by the recent rate cuts.

"But it is also important to say that there are many very good physicians who have stuck with us through some tough times," Bradley said. "These physicians have provided good services for our Medicaid recipients. We know it's difficult for physicians to do business with us: Our rates are low, our pay is slow and our paperwork is onerous. But we're trying to address that with Healthy Moms/ Healthy Kids."

Healthy Moms/Healthy Kids is slated to begin April 1, Bradley said, adding that under the program, primary care physicians will see additional rate increases for most services. To assure a steady cash flow, physicians in the Chicago area who sign up to participate in the managed care program also will receive a "capitation fee" for each IDPA patient who chooses them as his or her primary care physician, he explained. To reduce the department-imposed paperwork hassle for physicians, IDPA will implement "some form of electronic billing," the director noted.

"Our goal – to increase access to primary and preventive health care for Medicaid clients – will rely on your involvement for its success," Edgar said. "Thank you for your past understanding. I appreciate the vital role you perform in caring for Illinois' neediest." ■

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CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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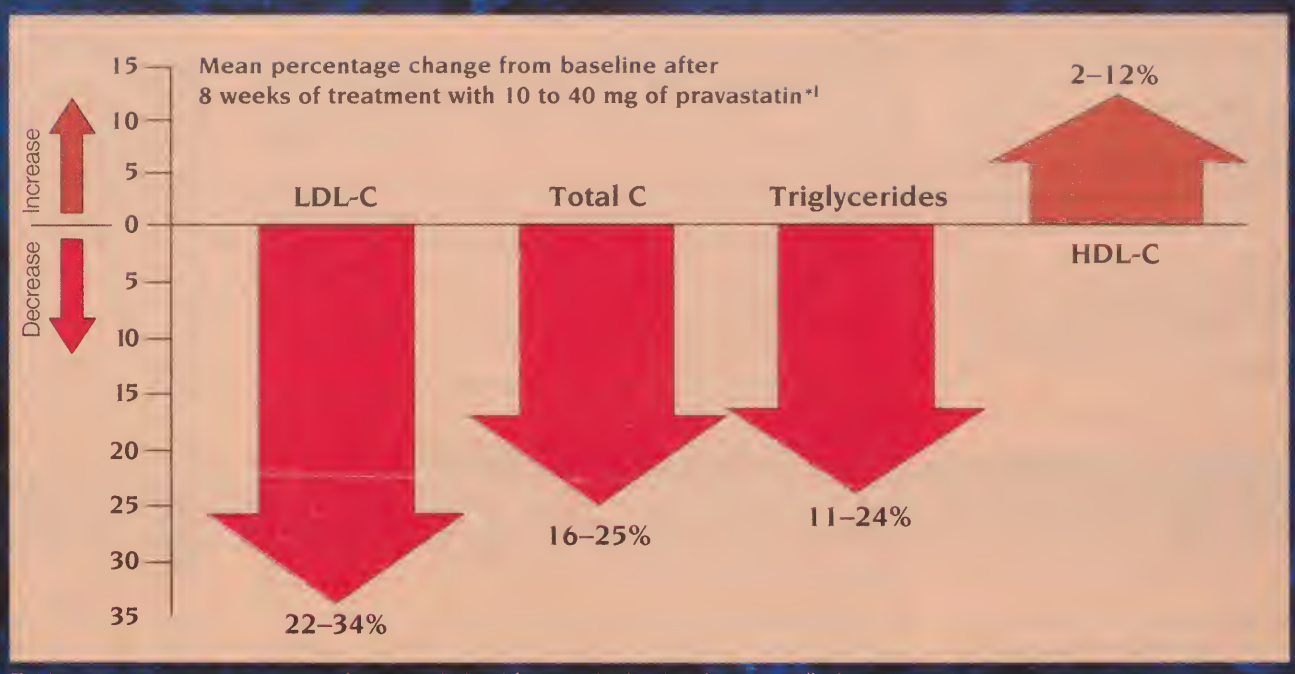
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Issued: September 1992

Bristol-Myers Squibb Company

Effective cholesterol control

Consistently and significantly reduces total C and atherogenic LDL-C; positively affects other key lipids



*Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

PRAVACHOL® (pravastatin sodium) is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease *or* unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin.

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol*. 1991;14:146-151.

PRAVACHOL™

pravastatin sodium 20 mg tablets

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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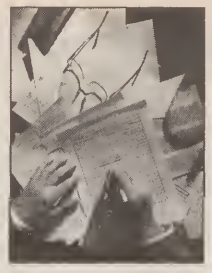
SAY MEDMAL CAPS ARE CONSTITUTIONAL (PAGE 10)

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JANUARY 29 1993

It's 1993, another year for license renewal

PAGE 17



Altering medical records can be hazardous

PAGE 9



AMY ROTHBLATT

THREE ILLINOIS MEDICAL SCHOOL RESEARCHERS, including the University of Illinois at Chicago's Susan Ross, PhD (above), provide "snapshots" of their studies and discuss the possible benefits of their findings. See story, page 12.

ISMS calls disciplinary report 'alarmist'

ILLINOIS RANKING: The Illinois State Medical Society is labeling as misleading a new report released Jan. 12 that ranks Illinois 36th in the nation in disciplining physicians. By Tamara Strom

[CHICAGO] The declining number of physician disciplines in Illinois is caused by reforms enacted in the disciplinary process five years ago, not a lax attitude toward policing the medical profession, said ISMS President Arvind K. Goyal, MD.

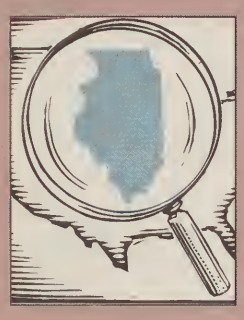
"There is nothing wrong with low numbers of disciplined physicians if the reason behind those low numbers is that our process is working," said Dr. Goyal, responding to the report issued by the consumer group Public Citizen. "The public needs to be reassured that if the number of disciplined doctors is decreasing, it is not because there are unethical or untrained physicians on the loose. It is because the majority of physicians in Illinois practice high-quality medicine in the most ethical manner. Those doctors in need of disciplining are few and far between."

Dr. Goyal credits changes in the licensing and disciplinary system invoked in 1987 – when the last major overhaul of the Medical Practice Act was completed – with the implementation of tougher standards.

(Continued on page 17)

INSIDE

Quincy hospital merger hits impasse
PAGE 4



Economic credentialing becomes a reality
PAGE 5

RBRVS update in effect for 1993
PAGE 3

DEPARTMENTS

News Briefs.....2
Commentary...6, 7
Malpractice Roundup.....10
Exchange Q & A.....11
Classifieds 15

Appellate court hears case of jailed physician

RULE 224: A Belleville physician receives the support of his peers during oral arguments. By Kevin O'Brien

[MT. VERNON] Oral arguments were heard Jan. 7 in Mt. Vernon in the case of a Belleville physician who was jailed with his attorneys when he was found in contempt of court during a deposition nearly a year ago. The Illinois State Medical Society filed an amicus curiae brief in support of James R. Vest, MD; Charlene A. Cremeens, an Illinois State Medical Inter-Insurance Exchange attorney; and Gerald L. Montroy, Dr. Vest's personal attorney. The three presented their argument against the misuse of Illinois Supreme Court Rule 224 – a rule generally used only to

(Continued on page 18)



STEVE MODERT

Attorneys presented oral arguments in the contempt case of James R. Vest, MD (above), who was jailed last April.

Medicaid recruiting MDs for Healthy Moms/Healthy Kids

MANAGED CARE PROGRAM: The Illinois Department of Public Aid began recruiting physicians for its new Medicaid program aimed at increasing primary care access for pregnant women and children. By Tamara Strom

[SPRINGFIELD] Physicians who have established relationships with Chicago Medicaid clients have been receiving requests from IDPA to become participating providers in the department's new Healthy Moms/Healthy Kids managed care initiative, set to begin April 1. IDPA defines an established physician-patient relationship with Medicaid clients as three visits within the last year.

The program goals are reining in Illinois' Medicaid costs and improving access by ensuring that women and children receive appropriate medical care, especially preventive care. The program is mandatory for all pregnant women and children under 21 in Chicago, according to IDPA.

In its Jan. 8 personalized letter to 3,700 physicians who have established relationships with at least 12 Chicago public aid patients, IDPA invites doctors to sign up for the program.

(Continued on page 19)

ISMS BEHIND THE SCENES

LEGISLATIVE CARDS HELP PHYSICIANS BECOME POLITICAL PLAYERS

In February, Illinois physicians will receive tools to help them become more active in the legislative process at the state and federal levels. The Illinois State Medical Society and Illinois State Medical Political Action Committee are sending doctors two cards – one for a Rolodex and one for a wallet – with the names, addresses and telephone numbers of their legislators in Springfield and Washington.

The cards will be mailed to more than 18,000 ISMS members – including retired doctors, students, and residents – as well as auxilians. All information printed on the cards is physician-specific; it reflects the new legislative and congressional districts created when the new maps were drawn last year.

"With health care reform at the forefront of many lawmakers' agendas, it's more important than ever for individual physicians to become part of the legislative process,"

(Continued on page 17)

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IDPR seeks medical coordinator

[SPRINGFIELD] The Illinois Department of Professional Regulation is seeking physician candidates for the position of chief medical coordinator. The position is full time and requires formulating medical opinions in department investigations. The medical coordinator fills the role of chief enforcement officer of the Medical Practice Act of 1987. He or she reports to the director, and serves in the Cook County area and other areas designated by the director.

Major responsibilities include reviewing and investigating complaints to the department; making recommendations to the Medical Complaint Committee and Medical Disciplinary Board regarding complaints and investigations; determining whether physicians have satisfactorily completed a program of care, counseling and treatment; monitoring physician assistants on probation; serving on the Medical Complaint Committee; writing requests for the issuance of subpoenas; and consulting with the director when summary suspension is warranted.

The chief medical coordinator may request immediate investigation of accusations of injury to a member of the public, reports of patient neglect and discrepancies in drug inventories. His or her opinion is used as expert opinion in prosecuting cases.

Inquiries about and applications for the position of chief medical coordinator should be made to the director, Illinois Department of Professional Regulation, 320 W. Washington St., 3rd floor, Springfield, Ill. 62786. ■

Illinois Supreme Court rules on disciplinary stays

[SPRINGFIELD] A Dec. 4, 1992, Illinois Supreme Court decision could have a significant impact on the medical community and the Illinois Department of Professional Regulation's ability to discipline physicians. In *Ardt vs. The Illinois Department of Professional Regulaion*, the court found unconstitutional a provision in the Dental Practice Act that precludes a reviewing court from granting a stay of an IDPR disciplinary decision pending appeal. Previously, reviewing courts were prohibited from granting such stays. The provision in the Dental Practice Act is identical to section 41 of the Medical Practice Act of 1987.

The ruling will likely cause individuals brought before IDPR to seek stays of disciplines more frequently. This could have the most significant impact when disciplinary action results from a direct concern about patient care, according to Saul J. Morse, Illinois State Medical Society vice president and general counsel. "It will likely be perceived as a limitation upon the department's ability to discipline Illinois physicians."

Stays may now be granted when physicians or dentists are reprimanded or fined, or even when their licenses are suspended by the department, Morse said. Technically, a physician's license could be suspended and he or she could continue practicing while awaiting an appeal, he said. Such an appeal process can sometimes take several years. The sections in both acts were specifically drafted to ensure that IDPR disciplinary decisions take immediate effect to protect the public health from physicians and dentists guilty of licensure violations.

The decision was made after the court reviewed the case of a dentist who was reprimanded by IDPR and fined $500 for violating advertising rules prohibiting the use of the terms "family dentistry" and "total comfort." The court upheld the discipline.

The ruling reverses prior Illinois appellate court decisions upholding section 41 against constitutional attack. But the supreme court ruled that the legislature cannot constitutionally limit the inherent powers of the judiciary granted under the Illinois Constitution of 1970. One of these powers is the ability to stay proceedings, such as disciplines, to maintain the status quo pending review, Morse said.

On Dec. 22, the department filed a petition asking the court to reconsider its position. No time period has been set for such a review; supreme court reconsiderations are rare, Morse said. ■

Study finds blood of friends, relatives no safer than blood bank donations

[SAN FRANCISCO] Blood donated by family members and friends is more likely to carry hepatitis B and some other diseases than is blood from anonymous donors, a government study reported at the recent annual meeting of the American Association of Blood Banks.

The finding does not necessarily mean there is higher risk to recipients of blood from friends and relatives, because most infected donations are likely to be identified by standard screening tests and discarded, according to the study's author. But the study does contradict the widely held belief that so-called directed donations from family or friends are safer, said Alan E. Williams, of the national laboratory of the American Red Cross in Rockville, Md.

"There is no evidence that individuals can select safer donors than the blood bank, which is experienced in doing that," said Williams.

In addition to hepatitis B, donations from friends and family were more likely to be contaminated with hepatitis C; syphilis; and HTLV-1, a virus that can cause cancer.

The one exception was the AIDS virus, which was found in 10 of every 100,000 blood bank donations, as opposed to 4.6 of every 100,000 directed donations, said Williams.

The study, financed by the National Institutes of Health, is the first large-scale examination of the safety of directed donations, said Williams. It involved examination of the records of 1,099,341 donations by 699,702 donors in Los Angeles, Oklahoma City, Detroit, San Francisco and the Baltimore-Washington area. ■



Philip to head Illinois Senate

Sen. James "Pate" Philip (R-Elmhurst) was recently appointed president of the Illinois Senate. Sen. Philip, who replaces outgoing president Sen. Philip J. Rock (D-Oak Park), is expected to strongly support such physician-oriented issues as tort reform and a market-based approach to health care reform.

FDA develops new rules to speed drug approval for serious diseases

[WASHINGTON] The U.S. Food and Drug Administration published new rules to speed the approval of drugs for patients with AIDS, cancer, Alzheimer's disease and other serious illnesses.

The new rules, published Dec. 11, 1992, apply when a drug provides a meaningful benefit over existing therapies. Also, if a drug is judged to be an effective treatment for a disease, under the new rules, the FDA can place it in a restricted distribution plan.

FDA Commissioner David A. Kessler, MD, said the new procedures will help streamline the development and review process without sacrificing good science. Applicable drugs and biological products must still meet safety and effectiveness standards required by law.

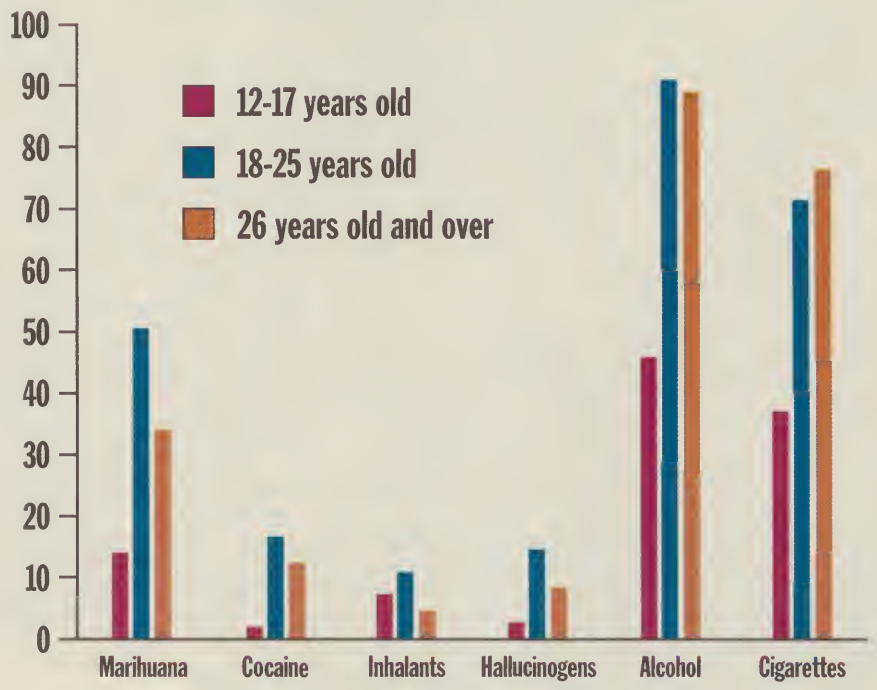
The new rules establish procedures for drug approval based on surrogate endpoints, such as laboratory tests or physical signs that do not in themselves constitute a clinical effect but that are likely to correspond to real benefits to the patient. This permits earlier approval than does the use of traditional endpoints, such as relief of disease symptoms or prevention of disability and death from the disease.

Once a drug has been approved for marketing, its sponsor must continue or conduct post-marketing human studies to confirm that the drug's effect on the surrogate endpoint indicates its clinical effectiveness.

One new drug – zalcitabine, known as ddC, used to treat the human immunodeficiency virus – was approved this past summer using a model of this process. ■

PHYSICIAN FACTS

Percent of people in the U.S. who have used drugs*



* Based on national samples of respondents residing in households. Subject to sampling variability.
Source: U.S. National Institute on Drug Abuse, *National Household Survey on Drug Abuse: 1991.*

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RBRVS update in effect for 1993

FEE SCHEDULE: Two conversion factors and a budget-neutral provision play key roles in the 1993 Medicare fee schedule.
By Anna Brown

[WASHINGTON] In preparation for the second year of the Medicare fee schedule, the U.S. Health Care Financing Administration of the Department of Health and Human Services published its resource based relative value scale final rule and notices for calendar year 1993 in the November 25, 1992, *Federal Register*. The published changes took effect Jan. 1, 1993, and reflect many recommendations from organized medicine. However, some of these recommendations were overshadowed by provisions mandated by HCFA.

In 1993, two conversion factors will be used to compute payment – one for surgical services and one for nonsurgical services. The surgical services conversion factor has been increased 3.1 percent over the 1992 figure, to $31.96, and the nonsurgical services figure has increased .8 percent, to $31.25.

Although rates for many services will be increased in 1993, some will be cut as a result of Medicare's provision requiring all changes to the relative value scale to be budget neutral. Consequently, all relative value units, whether revised or not, will be cut by 2.78 percent to accommodate the provision. According to HCFA, without this cut, the latest revisions would have cost Medicare $450 million over 1992's expenditures. HCFA's statutory mandate states that relative value changes cannot increase or decrease expenditures by more than $20 million. Budget-neutrality cuts were made across the board after all service revisions were made.

> *"Anybody can find something to complain about. But the overall feeling is that the system has to be continually modified and improved."*
>
> **JOHN F. SCHNEIDER, MD**

"Doctors can't say they disagree with budget neutrality, but there are mixed responses," said John F. Schneider, MD, Third District Trustee and chairman of the ISMS Third Party Payment Processes Committee. One problem he sees is that specialties in which the relative value units were revised upward more than 2.78 percent before the budget-neutrality cuts, will benefit, and the rest will not.

Dr. Schneider said in some circumstances certain specialties will be penalized but others will benefit even though fewer procedures are performed – a practice he terms self-defeating. The two conversion factors are problematic, he said. "Making a lot of adjustments defeats the purpose of the system," he said, stressing instead the need for better definition of evaluation and management codes.

ORGANIZED MEDICINE was able to work within the limits set by HCFA, Dr. Schneider explained. The organization has been "seemingly responsive and getting better," he said. "Anybody can find something to complain about. But the overall feeling is that the system has to be continually modified and improved."

HCFA received comments from specialty medical societies on 791 RVUs in 1992, seeking increases for more than 700 RVUs. Had all increase requests been accepted, Medicare fee schedule expenses would have increased by more than $2.4 billion, according to the department. Overall, most increases were less than what had been requested.

Specialties that gained the most include pathology and psychiatry, while those that underwent cuts include orthopedic surgery, anesthesiology and radiology. As a result of this year's changes, family physicians and internists face additional increases of .7 percent by 1996, the year the fee schedule will be completely phased in, and specialties such as nephrology, neurology and cardiology will increase by 1.4 percent, 2.6 percent and 1.3 percent respectively.

Selected services for various geographical areas in Illinois will see modest changes from 1992. A total hip replacement will increase $25 in Champaign-Urbana, $10 in Cook County and $4 in Rock Island. Also in Champaign-Urbana, a coronary artery bypass will be cut from $2,631 to $2,551, in Cook County from $3,121 to $3,031, and in Rock Island from $2,200 to $2,135. Office visits for established patients will increase slightly in almost all areas of the state, from $33.89 to $34.41 in Cook County, from $24.57 to $26.10 in DeKalb, and from $27.43 to $28.47 in Springfield. ■

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REPORT FOR *Illinois Physicians*

More than 900,000 members participate in Blue Cross and Blue Shield of Illinois' PPO Programs. The following is the PPO Hospital Network effective January 1, 1993. If you would like a listing of PPO Physicians, please contact the Provider Assistance Unit at (312) 938-7340.

ILLINOIS

Aledo	Mercer County Hospital
Alton	Alton Memorial Hospital
Anna	Union County Hospital
Arlington Hts	Northwest Community Hospital
Aurora	Mercy Center for Health Care Services
Barrington	Good Shepherd Hospital
Belleville	St. Elizabeth Hospital
Belvidere	Highland Hospital, Inc.
	St. Joseph's Hospital
Benton	Franklin Hospital
Berwyn	MacNeal Hospital
Bloomington	BroMenn Regional Medical Center
	BroMenn Lifecare Center
	Eureka Community Hospital
	St. Joseph Medical Center
Blue Island	St. Francis Hospital
Breese	St. Joseph's Hospital
Canton	Graham Hospital
Carbondale	Memorial Hospital of Carbondale
Carlinville	Carlinville Area Hospital
Carmi	Carmi Township Hospital
Carrollton	Thomas H. Boyd Memorial Hospital
Carthage	Memorial Hospital
Centralia	St. Mary's Hospital
Centreville	Centreville Township Hospital
Chester	Memorial Hospital
Chicago	Bethany Hospital
	Charter-Barclay Hospital
	Chicago Osteopathic Hospital
	Children's Memorial Hospital
	Columbus Hospital
	Cook County Hospital
	Grant Hospital of Chicago
	Holy Cross Hospital
	Humana Hospital - Michael Reese
	Illinois Masonic Medical Center
	Jackson Park Hospital
	LaRabida Children's Hospital and Research Center
	Louis A. Weiss Memorial Hospital
	Mercy Hospital & Medical Center
	Mount Sinai Hospital & Medical Center
	Northwestern Memorial Hospital
	Our Lady of the Resurrection Medical Center
	Ravenswood Hospital Medical Center
	The Rehabilitation Institute of Chicago
	Resurrection Hospital
	Roseland Community Hospital
	Schwab Rehabilitation Hospital
	South Chicago Community Hospital
	St. Elizabeth's Hospital
	St. Joseph Hospital
	St. Mary of Nazareth Hospital
	Swedish Covenant Hospital
	University of Chicago Medical Center
Clifton	Central Community Hospital
Clinton	John Warner Hospital
Danville	United Samaritans Medical Center
Decatur	St. Mary's Hospital
DeKalb	Kishwaukee Community Hospital
Des Plaines	Holy Family Hospital
Dixon	Katherine Shaw Bethea Hospital
Downers Grove	Good Samaritan Hospital
DuQuoin	Marshall Browning Hospital Association
East St. Louis	St. Mary's Hospital
Effingham	St. Anthony's Memorial Hospital
Eldorado	Ferrell Hospital
Elgin	Sherman Hospital
Elmhurst	Elmhurst Memorial Hospital
Eureka	Eurkea Community Hospital
Evanston	Evanston Hospital
	St. Francis Hospital
Evergreen Park	Little Company of Mary Hospital
Fairbury	Fairbury Hospital
Fairfield	Fairfield Memorial Hospital
Flora	Clay County Hospital
Forest Park	Riveredge Hospital
Freeport	Freeport Memorial Hospital
Galena	Galena-Stauss Hospital
Galesburg	St. Mary's Hospital
Geneseo	Hammond-Henry District Hospital
Geneva	Delnor-Community Hospital
Gibson City	Gibson Community Hospital
Glendale Hts	Glen Oaks Medical Center
Glenview	Glenbrook Hospital
Greenville	Edward A. Utlaut Memorial Hospital
Harrisburg	Harrisburg Medical Center
Harvey	Ingalls Memorial Hospital
Havana	Mason District Hospital
Hazel Crest	South Suburban Hospital
Herrin	Herrin Hospital
Highland	St. Joseph's Hospital
Highland Park	Highland Park Hospital
Hillsboro	Hillsboro Hospital
Hinsdale	Hinsdale Hospital
Hoffman Estates	Humana Hospital
Hoopeston	Hoopeston Community Memorial Hospital
Hopedale	Hopedale Medical Complex
Jacksonville	Passavant Memorial Area Hospital
Jerseyville	Jersey Community Hospital
Joliet	Silver Cross Hospital
	St. Joseph Hospital
Kankakee	Riverside Medical Center
Kewanee	Kewanee Hospital
LaGrange	LaGrange Memorial Hospital
Lawrenceville	Lawrence County Memorial Hospital
Lincoln	Abraham Lincoln Memorial Hospital
Litchfield	St. Francis Hospital
Macomb	McDonough District Hospital
Marion	Marion Memorial Hospital
Maryville	Anderson Hospital
Mattoon	Sarah Bush Lincoln Health Center
McHenry	Northern Illinois Medical Center
McLeansboro	Hamilton Memorial Hospital
Melrose Park	Westlake Community Hospital
Mendota	Mendota Community Hospital
Metropolis	Massac Memorial Hospital
Moline	Trinity Medical Center - East Campus
Monmouth	Community Memorial Hospital
Monticello	John & Mary E. Kirby Hospital
Morris	Morris Hospital
Morrison	Morrison Community Hospital
Mount Carmel	Wabash General Hospital
Mount Vernon	Crossroads Community Hospital
	Good Samaritan Regional Health Center
Murphysboro	St. Joseph Memorial Hospital
Nashville	Washington County Hospital
Normal	BroMenn Regional Medical Center
	BroMenn Lifecare Center
	Eureka Community Hospital
	St. Joseph Medical Center
Oak Lawn	Christ Hospital
Oak Park	Oak Park Hospital
	West Suburban Hospital Medical Center
Olney	Richland Memorial Hospital
Olympia Fields	Olympia Fields Osteopathic Medical Center
Ottawa	Community Hospital of Ottawa
Palos Heights	Palos Community Hospital
Pana	Pana Community Hospital
Paris	Paris Community Hospital
Park Ridge	Lutheran General Hospital
	Parkside Lutheran Hospital
Pekin	Pekin Memorial Hospital
Peoria	St. Francis Hospital Medical Center
Peru	Illinois Valley Community Hospital
Pinckneyville	Pinckneyville Community Hospital
Pittsfield	Illini Community Hospital
Pontiac	St. James Hospital
Princeton	Perry Memorial Hospital
Quincy	Blessing Hospital
	St. Mary Hospital
Red Bud	St. Clement Hospital
Robinson	Crawford Memorial Hospital
Rochelle	Rochelle Community Hospital
Rock Island	Trinity Medical Center - West Campus
Rockford	Rockford Memorial Hospital
	St. Anthony Medical Center
	Swedish American Hospital
Rosiclare	Hardin County General Hospital
Rushville	Sarah D. Culbertson Memorial Hospital
Salem	Public Hospital of the Town of Salem
Sandwich	Sandwich Community Hospital
Savanna	Savanna City Hospital
Shelbyville	Shelby Memorial Hospital
Sparta	Sparta Community Hospital
Spring Valley	St. Margaret's Hospital
Springfield	Memorial Medical Center
Staunton	Community Memorial Hospital Association
Sterling	CGH Medical Center
Streator	St. Mary's Hospital
Sycamore	Sycamore Hospital
Taylorville	St. Vincent Memorial Hospital
Tuscola	Douglas County Jarman Memorial Hospital
Urbana	Covenant Medical Center Urbana
Vandalia	Fayette County Hospital
Watseka	Iroquois Memorial Hospital
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Winfield	Central DuPage Hospital
Wood River	Wood River Township Hospital
Woodstock	Memorial Hospital for McHenry County

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Dyer	Our Lady of Mercy Hospital
East Chicago	St. Catherine Hospital
Evansville	Welborn Memorial Baptist Hospital
Gary	Methodist Hospital
	St. Mary Medical Center
Hammond	St. Margaret's Hospital
LaFayette	St. Elizabeth Hospital & Medical Center
Merrillville	Methodist Hospital
Michigan City	Memorial Medical Center
Munster	The Community Hospital
South Bend	St. Joseph's Hospital
Terre Haute	Terre Haute Regional Hospital

IOWA

Clinton	Samaritan Health Systems
Davenport	Mercy Hospital
Dubuque	Finley Hospital
Keokuk	Keokuk Area Hospital

MISSOURI

Chesterfield	St. Lukes Hospital - West
Hannibal	Hannibal Regional Hospital
St. Louis	Barnes Hospital
	Cardinal Glennon Children's Hospital
	Christian Hospital NW
	Jewish Hospital
	SSM Rehabilitation Institute
	St. Anthony's Medical Center
	St. John's Mercy
	St. Louis Children's Hospital
	St. Louis University Hospital
	St. Mary's Health Center

WISCONSIN

Beloit	Beloit Memorial Hospital
Burlington	Memorial Hospital of Burlington
Fond Du Lac	St. Agnes Hospital
Kenosha	Kenosha Memorial Hospital
Monroe	St. Clare Hospital of Monroe
Waupun	Waupun Memorial Hospital

(1/29/93)

Quincy hospital merger hits impasse

PHYSICIAN REACTION: With the proposed merger of the city's two hospitals seemingly dead in the water, Adams County doctors are frustrated about the lost opportunity. By Tamara Strom

[QUINCY] Physicians in this small Illinois town strongly supported consolidation of Quincy's hospitals to deliver the best quality care for area residents. They still do.

But for the foreseeable future, St. Mary and Blessing hospitals will remain separate. Although the hospitals were "within weeks" of completing the merger to become "Providence Hospital," disagreements over administrative control in the new facility continue more than six weeks after negotiations ceased. The dispute has all but killed the consolidation effort.

The day negotiations broke down between St. Mary and Blessing, the 125-member Adams County Medical Society passed a resolution strongly supporting consolidation. "The arguments in favor of consolidation that were given to the medical staff and the community are still valid," the Dec. 14, 1992, resolution states. "Therefore, we strongly urge all parties involved in the original consolidation to resume negotiations in good faith for the betterment of the community." Quincy-area physicians – most of whom have medical staff privileges at both institutions – are disappointed that the failed merger cements continued duplication of services at the two hospitals. Many are concerned health costs in Adams County will rise.



Steven Ginos, MD, a Quincy family physician, said Adams County physicians believe the merger would be in the community's best interest.

"It seems likely we're in for a period of increased competition between the two hospitals," said William Holt, MD, an orthopedic surgeon practicing at the Quincy Physicians and Surgeons Clinic. "Almost everyone realizes that more competition [in health care] means higher prices. And there is still a question about whether the community and surrounding areas can really support two rural referral-type hospitals indefinitely."

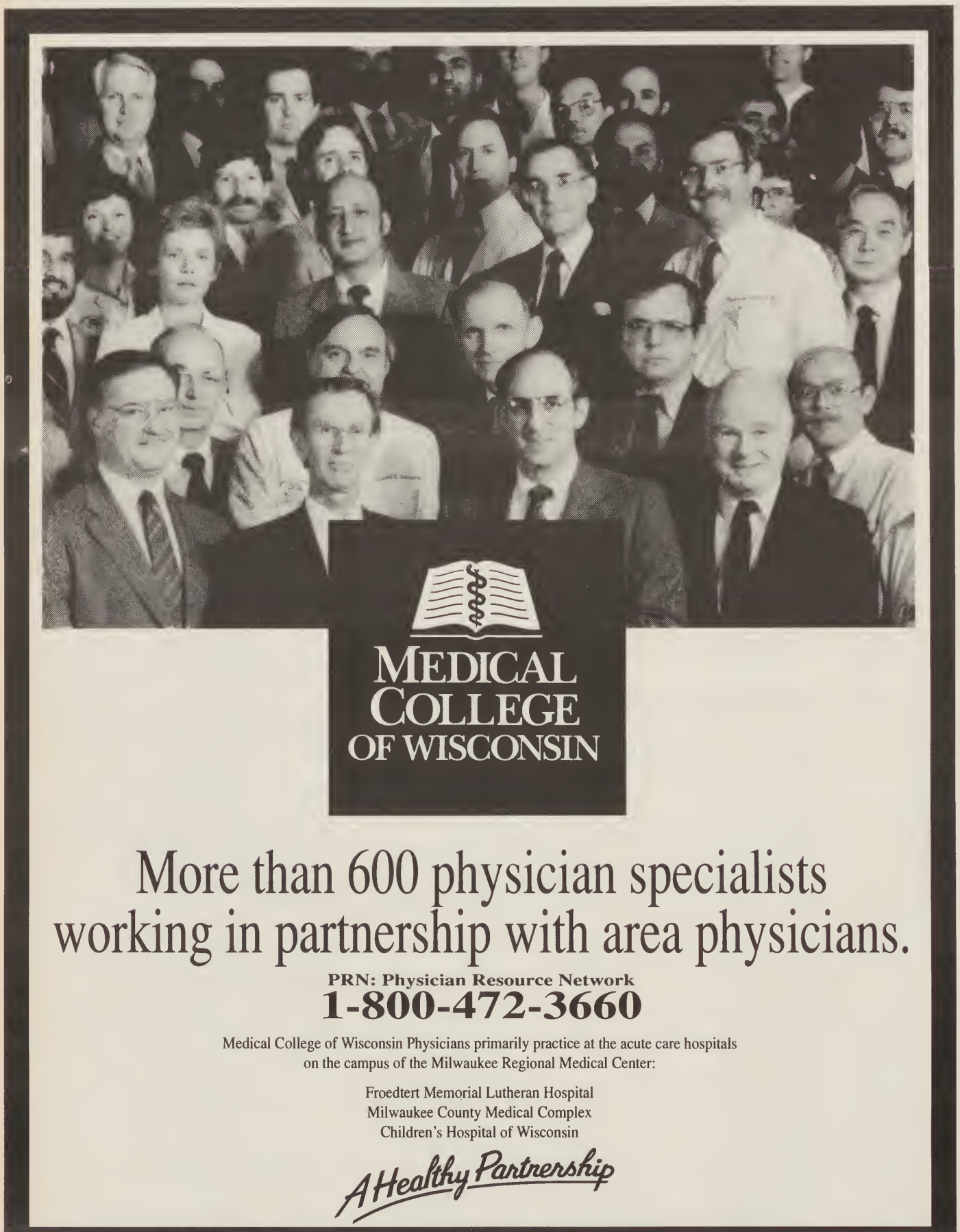
MANY OF THE HOSPITAL PATIENTS in Quincy come not only from within the city limits, but also from outlying communities such as Pittsfield, Rushville and Carthage, Dr. Holt explained. "Quincy has services such as neurosurgery that are not available in these smaller communities. Consolidating the hospitals would have increased the opportunities for offering more specialized services to a wider group of patients. A strong single hospital working in conjunction with the physicians' clinic would have been the nucleus for a very innovative health care delivery system. For now, that opportunity has been lost."

Officials from St. Mary and Blessing said the hospitals remain committed to consolidation. But they told *Illinois Medicine* the merger could proceed only if their differences about administrative control can be settled, a prospect both say is currently unlikely.

The two hospitals offer "basically the same services," said Steven Ginos, MD, a Quincy family physician, who serves as president of the Adams County Medical Society. "The merger was going to give the community the ability to focus on long-term goals such as improving technology locally. Now the money will go into duplication of services and maintaining the status quo."

Dr. Ginos said he sees sadness among his patients about the now unlikely merger. "Patients do ask us about the situation," he said. "It seemed something good was going to happen, and then it didn't."

Even though Adams County physicians believe the merger would be in the best interest of the community, they recognize their limitations in helping achieve a consolidation, Dr. Ginos said. "We pretty much realize we are powerless as a group to influence the situation any more than we've already done. We realize exactly who's in control. It's the hospital boards." ■



Economic credentialing becoming a reality

HOSPITAL CONTROL: In the ongoing struggle to keep themselves out of the red, hospitals are beginning to blur the lines between quality assurance and cost control. By Tamara Strom

[CHICAGO] Little by little, hospitals around Illinois are showing early signs of granting medical staff privileges to physicians based on whether doctors are making or losing money for hospitals, not the quality of medical care. It's called economic credentialing.

"The concept of economic credentialing is a kind of 'what-have-you-done-for-me-lately, Doctor' question hospitals are asking," said Dennis Brown, MD, chairman of the Illinois State Medical Society Hospital Medical Staff Section. "It's now a factor in recredentialing, where it had previously not been [at issue]."

Traditionally, the reappointment process is undertaken by the medical staff, with the actual granting of privileges performed by the hospital board, Dr. Brown explained. "But if the hospital management begins making these decisions from the beginning based on quotas, that's where you're dead," he said.

Dr. Brown said he believes primary care physicians are the most susceptible to economic credentialing "because they may be admitting to two or three different hospitals."

IN MOST HOSPITALS, the medical staff bylaws are silent about economic credentialing, Dr. Brown said. He recommended physicians ensure their hospital staff bylaws state that the credentialing process does not indicate minimum numbers of patients physicians must admit to a hospital or the kind of insurance those patients have. "Later, if the hospital board decides to [start economic credentialing], the fight is over a different issue – whether the hospital can unilaterally change medical staff bylaws," he said.

> *"The concept of economic credentialing is a kind of 'what-have-you-done-for-me-lately, Doctor' question hospitals are asking. It's now a factor in recredentialing, where it had previously not been [at issue]."*
>
> **DENNIS BROWN, MD**

Driving the move toward economic credentialing is increased competition among hospitals, the "proverbial bottom line," Dr. Brown said.

Gone are the days when the medical staff and the hospital management were "one big happy family," said Jerry Clousson, a Chicago attorney concentrating on health care law, including economic credentialing and medical staff bylaws issues. "It's just not that way anymore. Economic pressures have a tendency to push people apart."

And with the imminent changes in the nation's health care system, including the current battle cry for managed competition, the credentialing of physicians based more on their profitability than sound medical practice could be more commonplace, Clousson said. But physicians do not have to sit idly by and watch hospitals usurp control of the hospital credentialing and quality control processes, he added. There are several warning signs doctors can watch for and appropriate courses of action they can take to stem the trend.

PHYSICIANS SHOULD BECOME suspicious if a hospital insists on having a majority of management or administrative staffers on the medical staff quality assurance committee, Clousson said. Another warning is a hospital's attempt to set up its own quality assurance committees, mandating that all quality issues be channeled through that committee instead of the medical staff quality committee, he said. This committee would be established in the hospital's corporate bylaws as the hospital's quality assurance mechanism, he said.

"Physicians should make sure their medical staff exercises the primary responsibility for quality assurance or that the [medical] staff is determining whether a physician is exercising quality and economic efficiency in the delivery of care," Clousson said. Physicians should not "let that get away to hospital control.

"A medical staff must be able to increase its bargaining muscle by proving its position and pointing out what other [organizations] have said is proper," Clousson continued. For example, the Joint Commission on Accreditation of Healthcare Organizations lays the primary responsibility for quality at the feet of the medical staff and the medical staff departments, he said. In addition, a 1985 American Medical Association-American Hospital Association Joint Task Force report addresses these turf issues and outlines compromises, one of which is that physicians have the frontline responsibility for monitoring quality, he noted.

New payment strategies also are affecting hospital credentialing practices and quality assurance, Clousson said. "The trend is toward more employment of physicians and more independent contracting relationships so hospitals can control the cost of the product for their own interest," he said. Hospitals will continue to set up "centers of excellence," with third-party payers contracting for certain services with a few selected hospitals within a geographic area. "Through these payment concepts, hospitals [and payers] are making the decisions on who provides care based on who is the most efficient," he said.

To protect themselves, medical staffs should retain their own legal counsel, separate from hospital attorneys, recommended Clousson. "Medical staffs are unwise not to recognize that a hospital-employed attorney will put the hospital's interests first. [The attorneys] are working in the interest of who pays them."

Springfield cardiologist Wes Moses, MD, agreed. "When bylaws are written, it is usually done by hospitals and their legal staff representation, which could make them pro-hospital," Dr. Moses said. "Physicians tend to go along with what is written because bylaws are written in legal terms that could be hard for physicians to interpret."

Dr. Moses said Springfield-area physicians practicing at the city's two hospitals are currently dealing with a minor bylaws concern regarding the proper sanctioning of physicians so that patient rights are protected and doctors retain avenues for due process. "In my decades in practice, [I've seen] probably more harm has been done to patients by administrators than by physicians," he said, citing decisions by hospital management to delay equipment purchases based on economic considerations even though the equipment could benefit patients.

"It's the doctors, not the hospital administrators, who [are] the patients' advocates. Medical staff bylaws must have an equitable doctor-hospital balance to protect patients." ■

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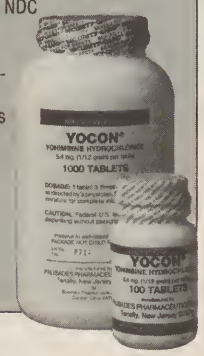
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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EDITORIAL

When quality of care meets the bottom line

Credentials. They give the bearer the right to exercise power and instill confidence in others. At least that's what they're supposed to do.

When it comes to doctors, their credentials center on their medical education, training, experience and skill. So it figures they would be judged on delivery of that professional expertise. The standard seems to be insidiously changing, though. Through economic credentialing, some doctors are being evaluated for hospital medical staff membership and privileges based on their profitability – whether they make or lose money for the hospital.

As reported by the American Medical Association, an American Hospital Association survey conducted in 1989 showed that only 4.7 percent of 3,400 hospital chief executives had programs linking credentialing with Medicare's prospective payment cost revenue profiles. But by 1991, an AHA survey of 500 hospital chief executives revealed that 71.4 percent prepared economic profiles of their physicians and used them for educational purposes. And 41.7 percent believed that in the following five years, hospitals would begin to tie privileging with physicians' economic contributions.

The reason for the shifting standard – from qualifications to profitability – is clear: pressure on hospitals to compete and improve the bottom line. But the possible consequences extend beyond economics.

With more hospital administrative staff than medical staff on some quality assurance committees, the potential exists for economic factors to overshadow quality of care and for doctors' performances to be judged by nonpeers.

Economic credentialing also has legal implications. The federal Health Care Quality Improvement Act of 1986 grants peer reviewers immunity from damages caused by the review only if the decision was "based on the competence or professional conduct of an individual physician." Peer review decisions based on competitive factors such as physicians' fees do not qualify for immunity.

There are positive things you can do. Be aware of the content of medical staff bylaws; the term "economic credentialing" may not be used, but the practice may be authorized nevertheless. Watch the use of physician data at your hospital. Make sure the medical staff is primarily responsible for quality assurance. And finally, when bylaw changes are considered, you may need to get legal representation for the medical staff that is separate from hospital legal counsel.

By paying attention to this issue early on, you can retain the benefits of your credentials – and your patients' confidence in them.

PRESIDENT'S LETTER

A pound of performance equals an ounce of image

By Arvind K. Goyal, M.D.



"Meetings with Illinois legislators in Washington, D.C., helped broaden the necessary perspective."

"I'll make a suit for you," agreed Walter Smith, a famous but overworked tailor, "but it won't be ready for thirty days." The customer was shocked. "Thirty days," he protested, "why, the Good Lord took only six days to create the entire world." "True," the tailor agreed, "but have you taken a good look at the world lately?"

As your president, I haven't had time these past eight months for any new suits but plenty of opportunities to take "a good look" at our world.

Since my last report to you in August, many more miles have been added to the meter. Neighboring state medical society meetings, the AMA Interim Meeting and meetings with Illinois legislators in Washington, D.C., helped broaden the necessary perspective. Visits to many more of our county medical societies and branches, several hospital medical staffs, the Southern Illinois Medical Association and specialty and ethnic medical societies were productive. Varied key messages were delivered to some local bar associations, the Illinois Retired Teachers Association, the Scoliosis Association, several Rotaries and business groups, men, women and auxiliary groups, churches, mayors in one county and other panels. Our teamwork shows at every place.

Seeing patients at free clinics in Peoria and Waukegan was a privilege and experience I will not forget. And I still remember the face of an uninsured baby I saw in Peoria. Both parents worked full time, yet the family's choices were limited by lack of insurance. Peoria's Heartland Clinic, like many others in the state, serves God's poor and needy. Participation in a day-long indigent care conference – the first ever anywhere – and the annual residency program director's seminar, both organized by your state medical society, allowed me some timely learning, listening and speaking on your behalf.

A special meeting held at the request of the 7,000-member Illinois Nurses Association at their building turned out to be some surprise. The nurses there represented some coalition for access to care. They wanted to work, not together with but independent of physicians! Physician supervision for assurance of patient care quality was an issue secondary to so-called autonomy, thus I heard.

Numerous media events were attended to, on the waves and in print, in Chicago and downstate. Two recent stories in a major Chicago newspaper – one on physician referral by a Florida reporter and another one on malpractice by the president of the Illinois Trial Lawyers Association – kept me busy and out of more trouble over the holidays! They were both responded to timely yet remain to be published! In a radio program call-in on health care reform in Champaign, the first caller asked if I was originally from India. As if that mattered in our health care reform debate!

Having school-age children at home, I am used to inquiries that do not have perfect answers. Sometimes you judge people by the questions they ask!

There were other questions asked both from outside and from within, some easy, others not. At a meeting with the medical student section recently, I was impressed with their involvement! Questions included: Should students and residents have "slotted" representation on the state medical society board? Should doctors trained outside of the United States be depended on for meeting our health care needs? Should admission standards be lowered to increase minority enrollment in medical schools?

And many excitements remain. With your continuing support, blessings and prayers, my head and my shoes should be able to hold up in the three months left to go. In Mike Ditka's words, "This too shall pass."

The plans for the Annual Meeting of your society at Oak Brook Hills Resort, April 23-25, are already under way. The dinner and orchestra music on the President's Night, this year on Friday, April 23, is customarily followed by a "brand name" entertainment. My wife, Renu, and I have suggested that the entertainment this year be elevated to a "generic" talent show in honor of Illinois physicians by the Illinois medical "family" – that is, brief stage performances by state and county medical society staffs, physicians and their families. Those willing and able to sing, play, dance, talk or do something else for fun that night will hopefully drop me a note this minute or call me at 1-800-782-ISMS, extension 1333, between 11 a.m. and 12 noon, the first Wednesday of next month, that is, Feb. 3, 1993. Would you or could you do it?



"Looks to me like some kind of rash ... I can't be sure though, considering I'm a doctor of higher mathematics."

HMSS annual meeting to be held Feb. 6

The eighth annual meeting of the Illinois State Medical Society's Hospital Medical Staff Section will be held Saturday, Feb. 6, from 9 a.m. to 4 p.m., at ISMS headquarters, 20 N. Michigan Ave., Suite 700, in Chicago.

The meeting will begin with a morning education session including two presentations. One will cover proposed revisions to the standards of the Joint Commission on Accreditation of Healthcare Organizations as they affect medical staffs; the other program will address the Illinois PRO's 4th Scope of Work. A business session will be conducted in the afternoon.

Attendees may register on-site. For more information, call (312) 782-1654, ext. 1147. ■

GUEST EDITORIAL

Economic credentialing in a nutshell

By Elizabeth A. Snelson, JD

In its 1990 study, the California Medical Association defined economic credentialing as the "use of economic criteria which do not apply to quality to determine a physician's qualifications for the granting or renewal of medical staff membership or privileges." The issue is not a simple one. Data such as the number of diagnostic tests ordered per case apply to quality but also have direct economic consequences. The CMA study "Exclusive Contracts and Economic Credentialing: Potential for Abuse in the Quality Assurance System" also delineates which credentialing factors with economic ramifications are nonetheless legitimate quality-assessment criteria and which criteria are strictly economic.

Economic credentialing is not subject to the same legal protections that cover traditional credentialing and peer review. Immunities such as those available under the Health Care Quality Improvement Act apply to only those professional review activities related to quality of patient care.

Economic credentialing is often implemented through an administrative process that parallels and thus bypasses medical staff bylaws. The protections that are otherwise afforded medical staff members and applicants do not apply, and the medical staff, through its departments and committees, does not have input into the credentialing criteria. Physician and medical staff involvement in selecting medical staff members is eliminated.

The most alarming result of economic credentialing is the subordination of patient care to fiscal concerns. Physicians whose patients insist on contracting economically inefficient diseases can find themselves without the hospital privileges necessary to administer treatment.

For the most part, hospitals depend on physician admissions for revenue. Some admissions are money-losers due to the type and severity of illness, the restrictions of the patients' health or entitlement plans, or the lack of coverage or financial resources. The hospital may not be able to get along without participating in certain plans and may not be able to discriminate against the poor, but it may be able to stop the fiscal hemorrhage by placing direct pressure on the source – physicians whose practice includes the poor or underinsured.

In my experience as medical staff legal counsel, economic credentialing appears in a variety of subtle guises scattered throughout hospital and medical staff bylaws, policies and other documents. Medical staff development plans are an increasingly popular high-yield source of economic credentialing mechanisms. So-called preapplication forms often call for economic data regarding the applicant and reapplicant, which may result in the physician's being rendered ineligible for a real application.

Physician profiling, using data collected by hospital billing software or other systems common to every hospital, provide the data on which economic credentialing can be based. Finally, and perhaps most unfortunately, almost every set of medical staff bylaws – usually unbeknownst to the medical staff – contains provisions permitting economic credentialing.

Thoroughly reviewing the bylaws and policies from a medical staff perspective can effectively screen for potential economic credentialing criteria. These and other potential sources of economic credentialing should be known and monitored by every medical staff.



Elizabeth A. Snelson, JD, *is in the private practice of law in St. Paul, Minn., and represents medical staffs and physician interests across the country.*

GUEST EDITORIAL

Unlimited care for some or basic care for all?

By Biswamay Ray, MD

America is a country of abundance, but still there is lingering hunger. This country has one of the highest standards of living, but still there are approximately 1 million homeless people nationwide on any given day. Our health care system is no exception to this contradiction. The citadel of the highest quality of medical care in the world offers little comfort to the 37 million people who have no health insurance and only limited access to health care.

It is obvious that the status quo in health care cannot and should not be maintained. Change is inevitable. The question is, what change? And at what price? One can only hope that instead of sweeping changes, genuine efforts will be made to blend the strengths of the current system with other innovative ideas to extend health care to all at a reasonable cost, without compromising the quality of care.

In the process, experiments will be necessary. As experiments go, some will succeed, others will fail, and many more may be unpleasant and may even appear to be unethical. The prospect of these experiments raises several questions: What should be the limit of such experiments? Can they be on the cutting edge? Are they ethically or morally right? Are they causing more suffering than they purport to alleviate, or do they discriminate against a certain segment of our population?

One thing is certain: The concept of access to unlimited care for all people all the time can exist only in Utopia. The fundamental question therefore remains: Should there be comprehensive care for some people or basic care for all people – many of whom cannot otherwise afford any?

The Oregon health care proposal was based on the second premise and advocated providing basic care for all state residents by expanding Medicaid coverage to include 120,000 people ineligible for the program, bringing the total up to 450,000. The plan called for rationing health care services by ranking diseases to be treated and procedures to be offered to patients based on the most beneficial use of limited financial resources.

Although the plan was approved by the Oregon Health Services Commission in 1991, it was blocked by the federal government. On the grounds that the plan violated the Americans with Disabilities Act, the federal government denied Oregon the needed waiver to implement its plan.

Rationing of health care, whether we admit it or not, already exists. In truth, inaccessible, unaffordable and delayed health care are only different aspects of such rationing. The Oregon health plan, in a bold move, openly subscribed to rationing of care for the purpose of extending care to all people in need.

In their quest to create a model health care plan, the states should be allowed to engage in a broad field of experimentation, even if that means narrowing the field of available medical services by restricting the choices. The federal government can always keep a watchful eye on any such experiment by periodically evaluating the programs and assessing the collective benefit (such as expansion of coverage to include all needy people) or collective suffering (such as that caused by the denial of treatment for certain diseases). Many valuable lessons can be learned from such experiments, which may ultimately be a benefit to all.

In this rapidly changing environment of health care reform proposals and given the new administration's promise for a major legislative initiative with emphasis on managed competition and global budgets, one has to wait and see what the future holds.

Whether or not the Oregon plan is ever implemented, however, it has already served a purpose by stirring debates and focusing our attention on issues that have long needed to be addressed. In its own way, the Oregon plan has already become a landmark.



Biswamay Ray, MD, *practices urology and oncology in the Chicago area and is a Third District Trustee of the Illinois State Medical Society.*



WM. DANIELS/THE PHOTO PARTNERS

Vice President of Claims Tim Saunders congratulates January Employee of the Month Diana Denton on her outstanding service.

'Outstanding' employee honored in January

[CHICAGO] "It is my understanding that [the Illinois State Medical Society and] ISMIS will be awarding achievement awards to outstanding employees," began the letter from a Cook county physician in nominating January's Employee of the Month. "Let me be the first to applaud the efforts of your employee, Diana Denton. Her efforts at making [me] feel comfortable with an otherwise totally unpleasant experience can only be described as outstanding!"

In Denton's position as a professional liability supervisor in the claims division, she works daily with physician policyholders facing malpractice lawsuits.

"As a defendant, I myself was on the stand five days, during which time I found Diana to be supportive and encouraging," the physician wrote.

Donald A. Udstuen, secretary/treasurer and chief operating officer of the Illinois State Medical Insurance Services, said Denton exemplifies what the "Physician First Service" initiative is all about. The initiative, begun in September 1991, is designed to improve policyholder service.

Denton attributes her success to support from fellow employees and the initiative itself. "I believe in this service initiative," said Denton. "That is why I do my job every day – for the doctors."

Denton, who has been with ISMIS since 1989, also serves on the Physician First Service Steering Committee and the Claims Subcommittee.

Denton's caring attitude extends beyond ISMIS: she has donated her award check to a battered-women's shelter in DuPage County.

All permanent, full-time ISMS/ISMIS employees, with the exception of senior management, are eligible for the Employee of the Month award. To nominate a staff member, contact the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■

BECAUSE APPROXIMATELY 60% OF PATIENTS WITH PERSISTENT ANXIETY MAY EXHIBIT DEPRESSIVE SYMPTOMS...[1]

BuSpar® 10mg (buspirone HCl)



Now indicated for the relief of persistent anxiety with coexisting depressive symptoms.*

▲ Anxiolytic efficacy demonstrated in anxious patients with or without coexisting depressive symptoms.[2]

▲ Relief of anxiety symptoms begins within 1 week, progresses steadily through the fourth week of therapy.[3]

▲ Nonaddictive, no more sedation (10%) than seen with placebo (9%).[4,5]

▲ The more commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%).

Progressive Relief of Persistent Anxiety.

*BuSpar is not indicated for the relief of primary depressive disorder.

Please see references and brief summary on adjacent page.

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BuSpar® (buspirone HCl)

References: 1. Data on file, Bristol-Myers Squibb Company. **2.** Cohn JB, Bowden CL, Fisher JG, Rodos JJ. Double-blind comparison of buspirone and clorazepate in anxious outpatients with or without depressive symptoms. *Psychopathology* 1992;25:10-21. **3.** Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multistudy, double-blind evaluation of buspirone. *Neuropsychobiology.* 1989;21:124-130. **4.** Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med.* 1987;82(suppl 5A):20-26. **5.** Newton RE, Marunycz JD, Alderdice MT, Napoliello MJ. Review of the side-effect profile of buspirone. *Am J Med.* 1986;80(suppl 3B):17-21.

Contraindications: Hypersensitivity to buspirone hydrochloride.

Warnings: The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

Precautions: ***General*** – *Interference with cognitive and motor performance:* Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable; therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients: Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdraw patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

Possible concerns related to buspirone's binding to dopamine receptors: Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

Information for Patients – Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding; and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

Drug Interactions – Concomitant use with other CNS active drugs should be approached with caution (see **Warnings**). Concomitant use with trazodone may have caused 3- to 6-fold elevations of SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

Carcinogenesis, Mutagenesis, Impairment of Fertility – No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

Pregnancy: Teratogenic Effects – Pregnancy Category B: Should be used during pregnancy only if clearly needed.

Nursing Mothers – Administration to nursing women should be avoided if clinically possible.

Pediatric Use – The safety and effectiveness have not been determined in individuals below 18 years of age.

Use in the Elderly – No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

Use in Patients with Impaired Hepatic or Renal Function – Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

Adverse Reactions (See also Precautions): ***Commonly Observed*** – The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

Associated with Discontinuation of Treatment – The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

Incidence in Controlled Clinical Trials – Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: *Cardiovascular:* Tachycardia/palpitations 1%. *CNS.* Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. *EENT:* Blurred vision 2%. *Gastrointestinal:* Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. *Musculoskeletal:* Musculoskeletal aches/pains 1%. *Neurological:* Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. *Skin:* Skin rash 1%. *Miscellaneous:* Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

Other Events Observed During the Entire Premarketing Evaluation – The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. *Cardiovascular* – frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. *Central Nervous System* – frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. *EENT* – frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. *Endocrine* – rare: galactorrhea, thyroid abnormality. *Gastrointestinal* – infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. *Genitourinary* – infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. *Musculoskeletal* – infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. *Neurological* – infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. *Respiratory* – infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. *Sexual Function* – infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. *Skin* – infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. *Clinical Laboratory* – infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. *Miscellaneous* – infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

Postintroduction Clinical Experience – Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

Drug Abuse and Dependence: ***Controlled Substance Class*** – Not a controlled substance.

Physical and Psychological Dependence – Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

Overdosage: ***Signs and Symptoms*** – At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

Recommended Overdosage Treatment – General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

U.S. Patent Nos. 3,717,634 and 4,182,763

MJL8-4270R2

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Malpractice Roundup

PAGE 10

ISMIE Update

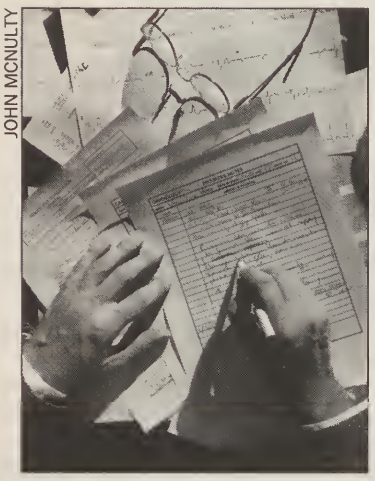
Court to review punitive damages

PAGE 11

Altering medical records can be hazardous

RECORDS: To reduce their risk, physicians should follow defense attorneys' advice on correcting mistakes. By Tony Sullivan

[CHICAGO] Physicians who have been sued for malpractice and then alter a patient's medical records expose themselves to serious consequences, warn malpractice defense attorneys. The act can result in judgments against their physicians and can jeopardize their malpractice insurance coverage. And it can give some defense attorneys nightmares.



JOHN MCNULTY

Robert Baron, a malpractice defense attorney with Rooks, Pitts & Poust in Joliet, can attest to that. He recalled a malpractice lawsuit in which the plaintiff's attorney accused the physician defendant of writing a note in the medical record to admit the plaintiff to the hospital after the patient left his office and after the lawsuit had been filed. The words "admit to hospital" were not in normal sequence with other notes and were written in a different-colored ink. In this case, however, the action proved to be defensible.

"In that case we were able to explain that, yes, a different pen was used because the physician made that recommendation standing with the patient outside the treatment room to discuss some test results," said Baron. "The nurse had given him the chart in the hallway, and the physician went to the closest nurses' station and used a different pen.

"That was a case in which we had an honest answer for the allegation, but it still causes you nightmares wondering what will happen if the jury doesn't buy it," he said.

Fortunately, the jury believed Baron's argument, and the physician was acquitted. "But if the jury thought for a moment that he had truly altered his records, we could have lost an otherwise defensible case." That's true of most suits involving alleged or actual alteration of medical records, Baron said.

IN MOST MALPRACTICE LAWSUITS, proof that a physician altered a medical record after the suit was filed is all a plaintiff's attorney needs to win a malpractice case, even if there was no medical negligence. "Once a physician alters a medical record there's a presumption in the eyes of the jury that he's attempting to cover up a mistake," said Gary Peplow, a malpractice defense attorney with Heyl, Royster, Voelker & Allen in Peoria. "Even if no mistake has been made, when you go back and alter a record, you're creating an impression that you made a mistake, and now you're going back and trying to change it. Once you've done that, the case becomes indefensible even if [you] really didn't do anything wrong."

Physicians who alter a medical record almost invariably get caught, Peplow said. Many think that once they're sued, all they need to do is add a few words to the record to clarify the reason for a certain course of treatment, and all will be well. But usually by the time a suit has been filed, the plaintiff's attorney already has a copy of the original medical record. If wording inconsistencies between the two sets of documents arise during discovery, it's usually "case closed" for the physician defendant.

Forensics advancements make it even more difficult for an altered medical record to go unnoticed. In one malpractice case in which Baron is involved, the medical records are undergoing handwriting and "ink drying" analyses to determine whether they've been altered. The ink drying analysis will show when the written entries were made. If the results confirm an entry was made after the lawsuit was filed, the physician defendant could be in trouble, Baron said.

Of course, these warnings don't mean physicians can't or shouldn't correct an inaccuracy or clarify a note in the medical record if it's warranted. But make the correction as soon as possible after providing the related treatment and follow accepted correction procedures. Defense attorneys recommend drawing a line through the incorrect information, adding the correct information above or near the original information, and dating and initialing the correction. It's also helpful to note above the line or close to the correction that an error was made.

DATING AND INITIALING a correction is critical, said Baron. "A lot of people make changes just by putting a line through the information and writing the new information near it. But if you don't initial it, you expose yourself to debate over who made the change. And if you don't date it, you expose yourself to debate that says you made the change after the lawsuit was filed."

Many hospitals have established procedures for correcting

(Continued on page 10)

ISMIE active policyholders by territory*

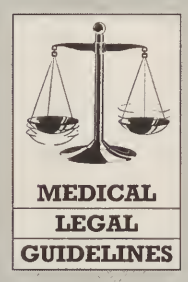


* ISMIE territories reflect increased risk, Territory I being the highest and Territory III the lowest.

Source: Illinois State Medical Insurance Services. As of June 30, 1992.

Ethics and physicians' right to advertise

Editor's note: This is part of a series covering medical-legal issues. Written by the Illinois State Medical Society Medical Legal Council, the information addresses legal concerns that physicians most commonly express to ISMS. It is intended to serve only as a general guide for physicians, not as specific legal advice.



According to the Medical Practice Act of 1987, Ill. Rev. Stat. 1991, ch. 111, pars. 4400-26 - 4400-27, the following information may be advertised:

1) The person's name, title, office hours, address and telephone number;
2) Information pertaining to the person's areas of specialization, appropriate board certification or limitation of professional practice;
3) Information on usual and customary fees for routine professional services offered, which information shall include notification that fees may be adjusted due to complications or unforeseen circumstances;
4) Announcement of the opening of, change of, absence from or return to business;
5) Announcement of additions to or deletion from professional licensed staff;
6) The issuance of business or appointment cards.

Further, according to the Medical Practice Act of 1987, Ill. Rev. Stat. 1991, ch. 111, pars. 4400-26 - 4400-27, the following information may not be advertised:

1) Testimonials or claims of superior quality of care to entice the public;
2) Fee comparisons of available services with other physicians;
3) Professional services which the offeror is not licensed to render;
4) Statements which contain false or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition;

(Continued on page 11)

Two state courts say medmal caps are constitutional

[WASHINGTON] As reported in *Business Insurance*, the U.S. Supreme Court refused to hear a constitutional challenge to Missouri's 1986 law that caps noneconomic damages in medical malpractice suits. The law was first challenged in 1988 by the family of an 8-year-old girl who suffered brain damage due to an anesthesia accident during surgery. A jury awarded the family $20 million, but the trial judge reduced the award to $3.1 million based on the cap. The family appealed to the Missouri Supreme Court arguing the cap violates constitutional guarantees of due process and equal protection, but the state court upheld the cap as constitutional.

In a similar action the Louisiana Supreme Court ruled in a 4-3 decision that its state medical malpractice act provides an adequate remedy for individuals and does not infringe on fundamental constitutional rights. Louisiana's law limits its liability to $100,000 on individual health care providers enrolled in the Patients Compensation Fund. PCF may then be liable for up to an additional $400,000, plus future medical expenses.

As reported in *Capsules,* the official newsletter of the Louisiana State Medical Society, LSMS president Pattie W. Van Hook, MD, said the system compensates patients injured through negligence without creating another professional liability insurance crisis in the state. According to *Medical Liability Monitor* similar caps on medical malpractice awards are in effect in about 18 states. ■

Altering medical records

(Continued from page 9)

a medical record, according to Kevin Glenn, a malpractice defense attorney with Clausen, Miller, Gorman, Caffrey & Witous in Chicago. This usually involves filing a separate document. "You don't alter the incorrect document. You add a document that states the correct situation," Glenn said. "You note, 'On such and such a day, I learned that my prior document didn't properly reflect the situation. I recorded a temperature as 89.3, and it should have been 98.3.'

"That prior mistaken document is still going to be a good, valid document, other than that single corrected mistake," added Glenn. You just have to show that it [the correction] is a supplemental event. And you generally want to show a reason why you supplemented it. An incoming lawsuit is not the best reason."

Physicians should also keep in mind that they could lose more than a lawsuit by altering medical records improperly, Baron said. Improperly altering medical records may jeopardize a physician's future insurability with the Illinois State Medical Inter-Insurance Exchange.

To correct medical records properly and avoid liability, defense attorneys offer this advice:

- Try to make clear and complete notes the first time and make them contemporaneous with the event.
- Recognize that you can make mistakes in documentation and do not attempt to overcome a mistake by making another mistake.
- If you have made a mistake, complete a new record that supplements the original one or correct the original record by using the generally accepted procedure previously described.

Peplow said the basic rule is, "If you are sued, don't at that point – absolutely don't – alter the records, even if they are incomplete. If you do, you run the chance that it will catch up with you. And if it does, any chance of successfully defending a claim will be lost." ■

MALPRACTICE ROUNDUP

Malpractice costs could triple by year 2000

As reported in *Physicians Financial News,* a study conducted by Towers Perrin, an international management consulting firm, estimates medical malpractice was responsible for $9 billion of the $132 billion the U.S. tort system cost in 1991. That figure is growing by 12 percent annually – a rate that could triple medical malpractice costs to $27 billion by the year 2000.

The study estimates that of the total costs, 15 percent was spent on claimants' attorney fees, 18 percent for legal defense, 24 percent for administration, 22 percent for economic loss awards and 21 percent for pain and suffering. Based on published insurance industry tort data and the firm's internal state-by-state data base, the study analyzed the cost of the U.S. tort system from 1930 to 1991. ■

Surveillance videos must be disclosed

Medical Malpractice Law & Strategy reports the New York Court of Appeals ruled defense surveillance videos made to undermine a plaintiff's injury claims must be disclosed before trial. However, the tapes need not be turned over until plaintiffs have been deposed, eliminating the problem of testimony that has been tailored by plaintiffs. Defendants must disclose only films they intend to use at trial. The court said that film and videotape are extraordinarily manipulable media; therefore plaintiffs must be allowed to test the evidence's authenticity. ■

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Supreme Court to review punitive damages awards

PAYOUTS: A court decision could determine the constitutionality of punitive damages awards. By Anna Brown

[WASHINGTON] The U.S. Supreme Court will again decide the constitutionality of punitive damages awards when it reviews a West Virginia case involving a $10 million punitive award. In comparison only $19,000 was awarded for compensatory damages.

The case is being touted as the court's opportunity to clarify its 1991 decision to uphold the punitive damages award in *Pacific Mutual Life Insurance Co. vs. Haslip,* the Alabama case in which the court found that state guidelines for helping jurors assess punitive damages were adequate. The decision established a four-to-one ratio of punitive-to-compensatory damages as the guide for maximum punitive payouts.

However, many courts have found the *Haslip* assessment too vague and have continued to levy huge punitive fines, an example being the 1991 case in which a Cook County jury awarded the plaintiff the second-highest punitive award in the United States. The 127.7 million judgment, of which $3 million was compensatory, was against Upjohn Co. in a product liability suit in which the plaintiff's eye was permanently damaged when a physician injected it with a drug manufactured by the company. The physician, an Illinois State Medical Inter-Insurance Exchange policyholder, was acquitted.

As reported in *Business Insurance,* in the West Virginia case, the state's Supreme Court upheld punitive damages nearly 527 times higher than the compensatory damages because the defendant's acts were "really mean." In the case, *TXO Production Corp. vs. Alliance Resources Corp.,* a jury found for Alliance in a counterclaim against a suit filed by TXO claiming oil and gas rights to a tract of land. When it made the award, the jury did not find that Alliance had suffered any damages.

In Illinois, punitive damages awards are prohibited in medical liability cases. Defense attorneys have noted the value of the statute and the danger of allowing plaintiffs' attorneys to argue for punitive damages. ■

EXCHANGE Q & A

Q. I have always paid my quarterly Exchange premium around the 15th of the month it's due. This year I received notice that my policy would be canceled if I waited that long. Has the billing schedule changed?

A. Every quarter the Exchange bills for premium payments due on the first of July, October, January and April. Last year, if policyholders hadn't paid by these dates, they would have received a 15-day extension before termination. The grace period was shortened by five days this year. Over the next two years, the grace period will continue to shrink until coverage will be terminated for physicians who have not paid by the first of the month.

There is, however, a 10-day automatic reinstatement period after each termination date. ■

The right to advertise

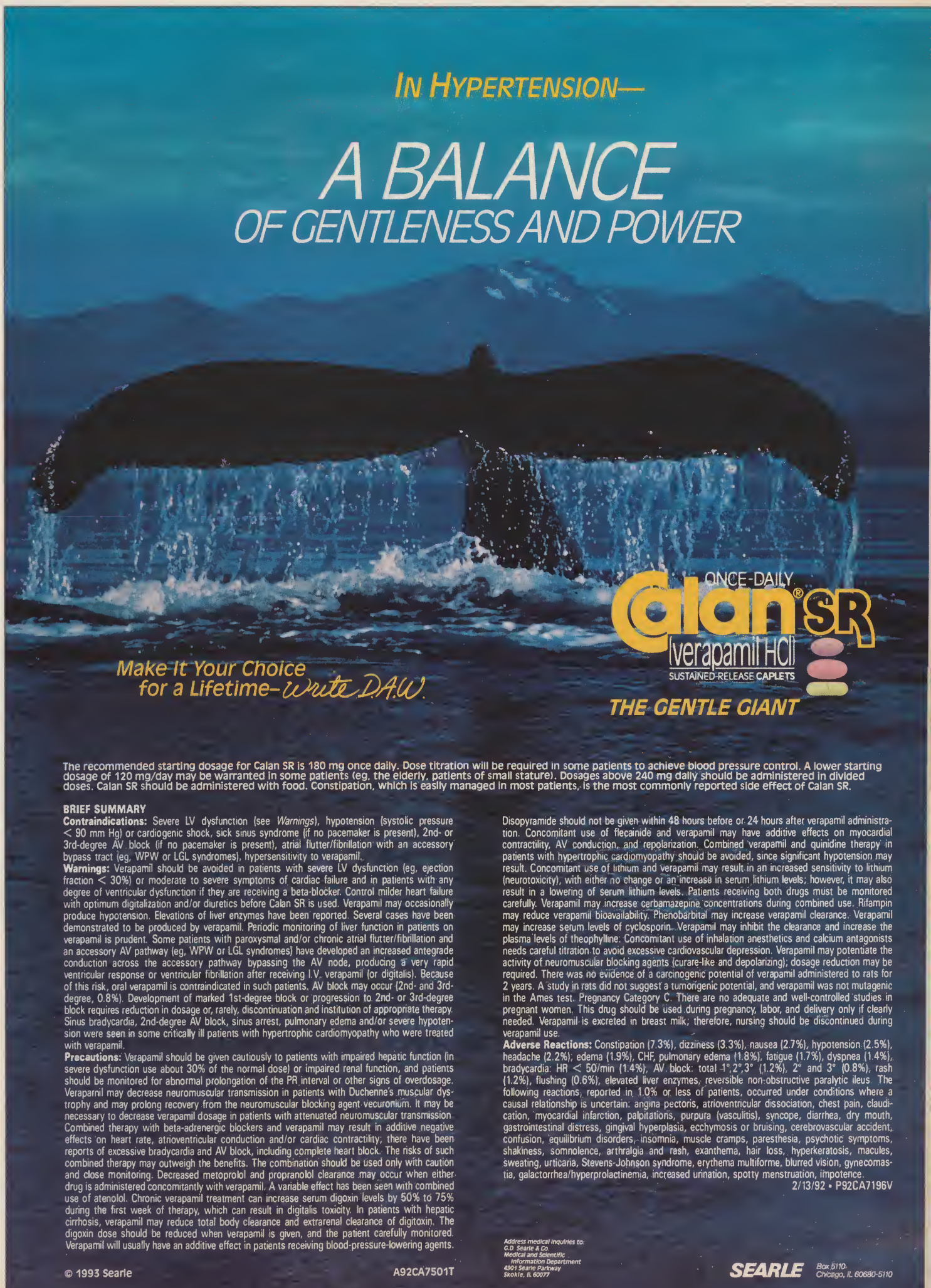
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5) That the offeror will accept assignment as payment in full, if the effect is to give the impression of eliminating the need for payment by the patient of any deductible or copayment.

The Illinois Department of Professional Regulation monitors compliance of the above stated guidelines.

Moreover, according to federal law, P.L. 100-360, the Office of Inspector General (OIG) is authorized to impose civil money penalties for the misuse of specified words, symbols and emblems which may convey a false impression that either an item or service was approved/endorsed by the Department of Health and Human Services (DHHS) or the responsible person or organization has some connection with or authorization from the DHHS for these programs. Specifically, any emblem, acronym, combination or variation of the following words is prohibited: Social Security, Social Security Account, Social Security Administration, Social Security System, Medicare and Health Care Financing Administration. There are exceptions to the use of the above words, symbols and emblems. ■

For more information, physicians may call ISMS medical-legal staff at (312) 782-1654 or (800) 782-ISMS.



The recommended starting dosage for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food. Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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MEDICAL SCHOOL RESEARCH

Illinois researchers lay groundwork for medical advances

Three scientists provide 'snapshots' of their studies and the possible consequences to patients.

BY KATHLEEN FURORE

Cardiac catheterization patients at an urban hospital's medical school. Schoolchildren at a medical school clinic. Mice in a university research lab. Although the subjects and settings are distinctly different, these three research projects could affect patient treatment in years to come.

To take a look at three studies under way, *Illinois Medicine* spoke with principal researchers from the University of Chicago Pritzker School of Medicine, the Northwestern University Medical School clinic and the University of Illinois at Chicago School of Medicine.

THE RESEARCH DONE by Matthew Sorrentino, MD, a cardiologist, on the abnormalities between the lipid composition of blood and the risk of coronary artery disease was a process he began while "sitting around the catheterization lab" during his residency.

"When I was learning to do cardiac catheterizations, I started looking at patients and wondering how some of the newer cholesterol particles in the blood, especially lipoprotein, related to coronary artery disease," said Dr. Sorrentino, an assistant professor of medicine at the U of C's Pritzker School of Medicine.

"We already knew lipoprotein contains cholesterol, so there was the assumption that it could be related to heart disease; and its molecular structure has very similar characteristics to plasminogen, one of the elements in blood that works on the clotting system and may have something to do with causing blood clots," he said."It was interesting because it straddled both mechanisms that are implicated in heart attacks."

To begin, he brainstormed the subject with colleagues and wrote a specific protocol detailing the hypothesis, data collection method, and nitty-gritty information such as how much blood

AMY ROTHBLATT



We're studying how the [mouse mammary] virus gets to the breast and what it does [when it gets there]. We want to know how it turns on in the breast cells, which is an important aspect of the study.

– Susan Ross, PhD

would be drawn. Then he submitted the protocol for approval to an institutional review board composed of university administrators and faculty, as well as qualified laypeople.

Dr. Sorrentino's protocol was approved in late 1989, the first time it was considered. And the study moved along quickly because he had built-in subjects – the next 250 patients scheduled to undergo cardiac catheterization at the U of C Hospitals.

"Patients were told the purpose of the study, its pros and cons, and risks," said Dr. Sorrentino. "In this case, the only real difference [between participants and nonparticipants] was that a vial of blood was drawn from patients in the study and sent for a lipoprotein and full cholesterol analysis. They actually didn't have to have a separate puncture, because we drew the blood through the catheter. There was no [added] risk to the patient."

Funding was not a problem either, since the only cost incurred was for the lipid analysis, which Angelo Scanu, MD, a co-author of the study and an expert in lipid abnormalities, funded from his lab budget. And instead of being paid, the researchers worked during their free time to complete all necessary analyses.

MARK GARRETT/PCI



When I was learning to do cardiac catheterizations, I started looking at patients and wondering how some of the newer cholesterol particles in the blood, especially lipoprotein, related to coronary artery disease.

– Matthew Sorrentino, MD

For approximately six months, Dr. Sorrentino, Dr. Scanu and the study's third co-author, Ted Feldman, MD, drew blood from and evaluated the subjects, who were not just Caucasian males.

"Most of the studies that have been done were done on Caucasian male patients, so we made a conscious decision to include blacks and females in our study," explained Dr. Sorrentino. "You can't necessarily take research done on Caucasians and extend it to everybody." This range in subjects was an important aspect of the study because the U of C Hospitals treat a large number of African-American and female cardiac patients.

Dr. Sorrentino added, however, that the "paucity of literature" about gender differences in coronary disease does not result from an intentional oversight.

"Studies originally focused on men because of the perception that men had more coronary disease, and they clearly do develop it at an earlier age [than do women]," said Dr. Sorrentino. "Also, the first government-sponsored studies – and there were a number of major studies in the 1970s – were done at VA hospitals, where the patients are men."

The most significant findings from the study, which were presented at the American Heart Association's 1992 annual meeting, confirmed the need to consider race and gender in analyzing data.

According to Dr. Sorrentino, not only did the study demonstrate a strong correlation between lipoprotein levels and the extent and severity of coronary disease in male and female Caucasians, but it also showed a weak correlation between lipoprotein and coronary disease in African-Americans – a more significant finding. However, Dr. Sorrentino said, "It seemed more important in black females than in males, but was not an independent risk factor if all other variables were taken away."

Although Dr. Sorrentino admitted his study "didn't address what to do" about high lipoprotein levels, he said it did uncover new information that will help doctors determine and modify their patients' risk profiles for coronary artery disease.

HOW SAFE, EFFECTIVE and feasible is it to put children on a low-fat diet? That's the question researchers at Northwestern hope the Dietary Intervention Study in Children – a multi-center collaborative trial funded by the National Heart, Lung and Blood Institute of the National Institutes of Health – will answer when the study is completed in the year 2000.

According to Linda Van Horn, PhD, associate professor of preventive medicine, registered dietician and DISC researcher, Northwestern's medical school was one of six centers chosen to participate in the study that was conceived by the NIH.

"The National Heart, Lung and Blood Institute of NIH issued an RFA [Request for Applications]," said Dr. Van Horn. "They actually generated the concept of DISC. Then we used a lot of creativity and scientific ingenuity to turn our idea into an actual protocol."

Dr. Van Horn explained that the NIH reviewed between 28 and 30 proposals and visited potential research sites before selecting participants. The time between submission of the completed RFA and funding approval was approximately one year.

Northwestern's researchers screened more than 10,000 children between the ages of 8 and 10 in Chicago metropolitan schools, looking for those whose cholesterol level registered in the upper 98th percentile for their age group. Qualified students and their parents were then invited for further screening, during which the study was described in greater detail.

"We're following the kids until age 18, so it takes a big commitment on the part of the parents," Dr. Van Horn said.

In early summer of 1987, the first of the 116 Chicago-area children selected for the study began what Van Horn called a "series of intensive intervention sessions." Those on a low-fat diet reported to a Northwestern medical school clinic once a week for the first six weeks, every other week for six weeks, once a month for six months, and finally once every three months, which

(Continued on page 14)

AMY ROTHBLATT



DISC researchers have been successful in recruiting more than 600 kids nationwide and successful in intervening [in their diets] and following them to see if we can keep cholesterol levels in children down and not interfere with their normal growth and development.

– Linda Van Horn, PhD

Illinois researchers

(Continued from page 13)

they are still continuing. Students in the control group are not following a regimented diet and report to the clinic annually.

Because the study is ongoing, Dr. Van Horn said she is "not at liberty to discuss the results" at this point. What she can say is that "DISC researchers have been successful in recruiting more than 600 kids nationwide and successful in intervening [in their diets] and following them to see if we can keep cholesterol levels in children down and not interfere with their normal growth and development."

SUBJECT RECRUITMENT wasn't a problem for Susan Ross, PhD, an associate professor of biochemistry at the UIC College of Medicine, conducting breast cancer research. Nor did she have to apply for funding. The subjects are mice, and her lab "essentially had money already because we've been working on the mouse mammary virus for 12 years, trying to find out how it causes mammary tumors in mice."

The new aspect of this ongoing research began two years ago, said Dr. Ross, when one of her former graduate students discovered that a protein generated by the virus first infects immune system cells and carries it to the mammary gland. Although Dr. Ross doubts that discovery in itself will greatly influence breast cancer treatment in women, she said another facet of the study might do so.

"We're studying how the virus gets to the breast and what it does [when it gets there]," she explained. "We want to know how it turns on in the breast cells, which is an important aspect of the study."

Dr. Ross said her lab's major contribution so far has been to alter the genetic structure of mice to make them resistant to the mammary tumor virus – a contribution she hopes will lead to the development of anti-viral agents against many viruses. Other researchers at UIC are equally hopeful and are drawing from Ross' work as they study other viruses that destroy the immune system.

"Many other human viruses, like HIV and rabies, probably affect the immune system in a similar way," Dr. Ross said, summing up how her work could affect treatment of not only breast cancer but also other human diseases. ■



OBITUARIES

* indicates ISMS member
** indicates member of ISMS Fifty Year Club

****Antoniou**
Christos A. Antoniou, MD, a pediatrician from Granite City, died Aug. 31, 1992, at the age of 63. Dr. Antoniou was a 1958 graduate of the Faculty of Medicine, Aristotelian National University of Athens, Athens, Greece.

****Biddlecombe**
Duncan Biddlecombe, MD, a general practitioner from Shelbyville, died Sept. 13, 1992, at the age of 81. Dr. Biddlecombe was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

***Boeshart**
Cletus B. Boeshart, MD, a surgeon from Belleville, died March 16, 1992, at the age of 70. Dr. Boeshart was a 1945 graduate of the St. Louis University School of Medicine, St. Louis, Mo.

****De La Vega**
Pompilio E. De La Vega, MD, a general practitioner from North Miami, Fla. (formerly of Antioch), died Nov. 13, 1992, at the age of 79. Dr. De La Vega was a 1941 graduate of Facultad de Medicina de la Universidad de La Habana, Havana, Cuba.

****Ioriatti**
John B. Ioriatti, MD, an ophthalmologist from Aurora, died July 10, 1992, at the age of 79. Dr. Ioriatti was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

***Spinka**
Harold M. Spinka, MD, a dermatologist from Chicago, died Sept. 18, 1992, at the age of 77. Dr. Spinka was a 1944 graduate of Chicago Medical School.

****Stringham**
James A. Stringham, MD, a psychiatrist from Evanston, died Aug. 29, 1992, at the age of 85. Dr. Stringham was a 1931 graduate of the Yale University School of Medicine, New Haven, Ct.

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Legislative cards

(Continued from page 1)

said ISMS Board Chairman Jere E. Freidheim, MD. "The input of grassroots physicians is critical to helping medicine be a major player in policy-making."

To ensure that the interests of physicians and their patients are well represented, doctors must do more than simply put their ballots in the ballot box on Election Day, noted IMPAC Chairman George T. Wilkins Jr., MD. Historically, IMPAC has supported many candidates who share medicine's views and even some candidates who do not always concur with our positions, Dr. Wilkins explained.

But regardless of whether they are traditional friends or foes of medicine, many legislators in both Springfield and Washington look to physicians for explanations about how proposed legislation may affect doctors in their offices, he added.

"Feedback we get from legislators consistently tells us they want to hear from doctors back home," Dr. Wilkins continued. "Particularly in our fight against the universal health bills in Springfield last year, people on both sides of the aisle said the personal contacts of ISMS and auxiliary members aided them in understanding why such a system would be so disastrous for Illinois. A call or letter from a constituent is a refreshing change of pace from the constant buzz of professional lobbyists who ring the rail at the state capitol. It makes a difference."

Dr. Freidheim added that with President Clinton's apparent commitment to enacting some type of health care reform, medicine must be adequately represented at the policy-making table. "No one is better suited to help frame the debate on how potential reforms will affect the quality of health care than the people who are charged with delivering that care – we physicians," Dr. Freidheim said.

ISMS member physicians who have questions about the legislative information cards may contact the Society's Governmental Affairs Division at (312) 782-1654 or (800) 782-ISMS. ■

Disciplinary report

(Continued from page 1)

Those ISMS-supported changes included raising the licensure fee from $100 to $300 to institute and maintain the new processes, he said. Illinois also has mandatory reporting laws that require medical societies, hospitals and insurers to report any adverse actions against physicians to the state licensing board.

These laws also mandate reporting of settlements or judgments in medical malpractice cases, although Dr. Goyal stressed that lawsuits in and of themselves are "not valid indicators of a physician's incompetence." In addition, the mandatory reporting laws allow for timely investigations by the Illinois Department of Professional Regulation and the disciplinary board, he said. In fact, even the Public Citizen report characterizes these reporting requirements as "fairly good."

"Because of the state's tough standards for initial licensing, IDPR tries to ensure that only those physicians with absolutely impeccable professional credentials get licensed in Illinois," Dr. Goyal explained. "Consequently, these physicians are less likely to need to be disciplined later."

Illinois' disciplinary process also makes distinctions between those few physicians who require disciplinary action in the traditional sense and those doctors who need only education, monitoring or counseling. The latter recommendations made by the disciplinary board are not reported as disciplines against a physician's license, Dr. Goyal noted.

"Some physicians require nothing but counseling, and there would be no benefit in restricting their practices," he said. Disciplinary actions recommended by the board are "strong enough and appropriate to prevent further problems," Dr. Goyal added. "There are not high numbers of physicians who continually circulate through the disciplinary process."

The disciplinary system here works to remove physicians who are truly incompetent and to educate other physicians to correct any practice problems they may have, Dr. Goyal said. "The system contains enough checks and balances so that the public is protected." ■

It's 1993, another year for license renewal

Believe it or not, it has been three years since you last renewed your medical license. If you haven't already done so, the Illinois Department of Professional Regulation is asking you to update your address now to ensure your receipt of renewal forms, which will be mailed this spring. Current licenses expire July 31, 1993.

The department must receive all address changes before March. Address changes may be submitted in writing only; they will not be accepted over the phone. Physicians may complete the form that will be printed in the Feb. 12 issue of *Illinois Medicine* to update addresses with the department. Those wishing to change their address on an Illinois controlled substance license should contact IDPR regarding specific procedures to follow. For more information, contact the Illinois Department of Professional Regulation, Licensure Maintenance Unit, 320 W. Washington St., 3rd Floor, Springfield, Ill. 62786; or call (217) 782-0458.

Make it a New Year's resolution. If you've moved, update your address, and when you receive your forms this spring, make license renewal a top priority. ■

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Appellate court hears case of jailed physician

(Continued from page 1)

determine parties involved in a potential suit – before the Illinois Fifth District Appellate Court. No suit had been filed against Dr. Vest when he was deposed April 2, 1992.

Dr. Vest, who received the support of at least 10 St. Clair County physicians present in the tiny courtroom, said he thought the hearing went well. "I think they got to the meat of the problem – that is, can a physician be brought into a courtroom without adequate consult, without adequate preparation, and be asked questions that may pertain to the care of a patient?"

Dr. Vest had been summoned to give a deposition last April by Belleville attorney Bruce N. Cook, who represented the estate of Melvin J. Roth, a patient who had died after contracting an infection and sepsis at St. Elizabeth's Hospital in Belleville in May 1991. Cook had not filed any suit and had summoned Dr. Vest under the little-used supreme court rule that permits testimony "for the sole purpose of ascertaining the identity of one who may be responsible for damages."

During the deposition, Dr. Vest declined on the advice of counsel to answer a question pertaining to the treatment of the patient because he and his attorneys believed it was beyond the scope of Rule 224. Consequently, St. Clair County Circuit Court Associate Judge James M. Radcliffe found Dr. Vest, Montroy and Cremeens in contempt of court and ordered them to jail. They were released from the St. Clair County Jail after five hours, when the appeals court stayed the contempt citation pending oral arguments.

"This was unlike any other proceeding in this state," Stephen R. Swofford, an attorney representing Dr. Vest and Cremeens in the appeal, told the court. "In any other proceeding, the respondent has a means to defend himself," because the respondent would at least know what he or she was being charged with.

He and Montroy, representing himself, also argued that Radcliffe abused his discretion when he ordered the three to jail, because Dr. Vest was within the scope of the rule when he refused to answer the question.

THE CRUX OF Swofford and Montroy's argument was that Cook used Rule 224 to bypass the certificate of merit provision of the Medical Malpractice Reform Act of 1985 in order to conduct illegal discovery. The provision states that the filing of a malpractice action must be accompanied by an affidavit from a third-party physician certifying that the suit has merit.

The only time Rule 224 may be used, Swofford told the court, is when "you don't have anybody you can potentially sue." But Cook already knew the identities of at least seven potential defendants, and was merely using Rule 224 to try to get information regarding the care of Roth, claimed Swofford and Montroy.

During the deposition, Cremeens had allowed Dr. Vest to answer some of Cook's questions, but drew the line at the question, "Did you attempt to take a test that would culture out the bacterial infection?"

Montroy told the panel, "A broad interpretation of Rule 224 – [allowing anything] other than names and addresses and the reading of the medical record – provides for the ambush of the person being deposed.

"The chilling effect of the jail door closing behind Dr. Vest and his attorneys was calculated to intimidate Dr. Vest and other potential respondents," Montroy continued. He said that if the appellate court affirms Radcliffe's action, the "floodgates will be opened" for trial judges to "use strong-arm tactics" to compel respondents to answer any question put to them under Rule 224.

Attorney Harriet Hamilton – standing in for Cook, who was in Belleville trying the new smoking and cancer suit against R.J. Reynolds Tobacco Co. – countered that a broad interpretation of Rule 224 is necessary because its real intent is to determine the person who is really responsible. She added that Cook "did not want to sue everyone; he wanted to find out who he should sue." She maintained that Rule 224 is "another appropriate means, in addition to a [certificate of merit] to find out what happened."

"I don't think it is an ambush to have [Dr. Vest] tell me what he did," Hamilton said.

Asked by one of the judges if a broad interpretation of the rule might force judges to personally supervise every deposition in the state, Hamilton said, "It's not fair to the patient to be cut out of the legal system because it costs money for a judge."

The appellate court is expected to rule on the case within the next eight weeks, as Cook successfully petitioned for expedited proceedings. It is expected that the losing side will appeal to the Illinois Supreme Court. ■

Anna Brown contributed to this story.

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Healthy Moms

(Continued from page 1)

Nearly 5,000 additional physicians who see 12 or fewer Medicaid clients will receive their letters shortly. The 200 Illinois physicians who see the most Medicaid patients – including 79 who see more than 1,500 – will get personal recruiting visits from IDPA staff.

But before signing the contract to participate, Illinois State Medical Society advisers recommend that doctors read the Physician Handbook and enrollment form carefully so they understand their responsibilities under the new program. For example, because Healthy Moms/Healthy Kids is a managed care program, the primary care physicians will be responsible for providing or recommending all non-emergency care needed by their patients. If a patient requires specialty care, the primary care doctor must make the appropriate referral, set up the patient's appointment and contact the program administrator to approve the specialist visit. Without such approval, the specialist will not be reimbursed by Medicaid. In fact, no doctor – including other primary care physicians covering for a doctor – can be paid without the approval of the client's assigned primary care provider.

IDPA requires participating physicians to have hospital privileges. Any physician providing prenatal care must also have delivery privileges. For primary care providers the department is mainly seeking general practitioners, internists, family physicians, obstetrician/gynecologists and pediatricians. Some exceptions to these rules will be allowed, according to IDPA's Physician Manual, but currently there are no criteria for these "extenuating circumstances."

> *"At this point it is impossible to dismiss our concerns about some aspects of the proposed program. We want to work together with the department and urge IDPA to work in a consultative capacity with the medical society."*
>
> **JOHN F. SCHNEIDER, MD**

All eligible Medicaid clients living in Chicago will be required to select a primary care physician, HMO or federally qualified health center. But if they fail to choose a provider, one will be assigned. All children under 5 and pregnant women also will be assigned case managers to help assure they see their physician and follow the doctor's instructions. Illinois physicians may opt to continue seeing all their current patients or choose to see fewer or additional patients. However, patients must choose their own provider. The enrollment form asks physicians how many total clients they will see, including how many new patients per month they would accept.

If physicians decide not to participate or do not become the primary care provider for all their current Medicaid clients, they must understand their legal responsibilities to those patients, including patient abandonment and liability issues. Although IDPA considers an established relationship to be three office visits within the last year, legal and ethical guidelines are more specific. Physicians are bound to ensure the continuity of their patients' care. To avoid improperly severing a relationship with a patient, doctors are encouraged to consult the ISMS medical-legal guidelines on abandonment, published in the Jan. 15 issue of *Illinois Medicine.*

BECAUSE ISMS' QUESTIONS about certain administrative aspects of the program have yet to be addressed, to date the Society has not endorsed the program. The ISMS Board of Trustees is scheduled to consider the issue at its Jan. 30 meeting in Chicago. The ISMS Committee on Third Party Payment Processes has been studying the program for several months as information from IDPA became available.

In its recommendation to the Board, the TPPP Committee conditionally supports Healthy Moms/Healthy Kids in concept and program intent. "We share the department's concerns that in some cases Medicaid clients are not receiving needed primary care services," said TPPP Chairman John F. Schneider, MD. He explained that many patients wait until they are very sick and then seek care from a hospital emergency room when a simple office visit at the beginning of the illness would have cured them sooner.

"We recognize that some degree of operational problems are inherent when any new program gets up and running," Dr. Schneider said. "But at this point it is impossible to dismiss our concerns about some aspects of the proposed program. We want to work together with the department and urge IDPA to work in a consultative capacity with the medical society."

Also still unclear is the process IDPA will implement for quality assurance. While physicians are committed to providing quality care to their patients, "implementing a quality assurance process should only be undertaken with input from organized medicine, including the specialty organizations," Dr. Schneider noted.

TPPP members also recommend that IDPA institute extensive patient educational efforts to encourage Medicaid clients to see their primary care physician as needed, thereby eliminating costly and inappropriate ER visits.

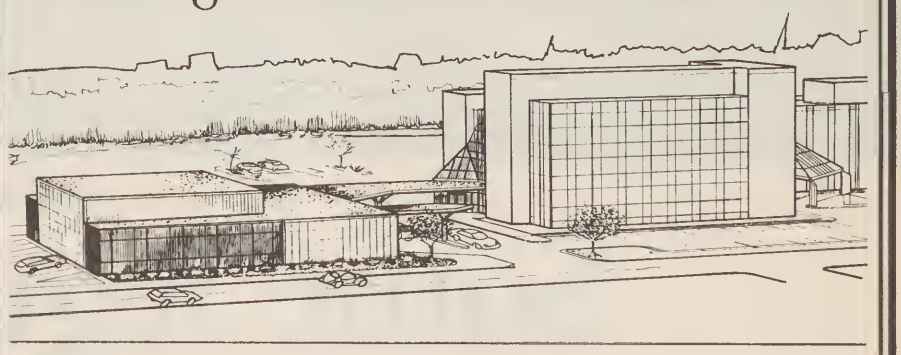
For more information about Healthy Moms/Healthy Kids or abandonment issues, contact the ISMS Division of Health Care Finance at (312) 782-1654 or (800) 782-ISMS. ■

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TAX SEASON UPDATE
PAGE 16



Lending an ear to cultural diversity
PAGE 12

Edgar renews call for caps

GOVERNOR'S MESSAGE: In his third state of the state address, Gov. Jim Edgar said it is time to enact meaningful tort reform. By Tamara Strom

[SPRINGFIELD] The gloom and doom from last year is gone. In its place is controlled optimism expressed by Gov. Edgar as he seemingly began his re-election bid Jan. 27 in delivering a good-news state of the state address. The 45-minute speech featured headlines Illinois physicians will like.

Illinois has finally escaped the "jaws of recession," Edgar told Illinois House and Senate members, 66 of whom were hearing the annual address for the first time as legislators. "I see a lot of new faces," he said. "We have an opportunity in the next few months to explore your fresh ideas, to build on what we already have accomplished. There is little question that Illinois is a stronger state today than it was a year ago."

Edgar's entire speech was well received on the Republican side of the aisle, with the GOP basking in its newly gained Senate majority. But the governor's most sustained round of applause came in response to his call for tort reform.



RON ACKERMAN

Gov. Jim Edgar's state of the state address Jan. 27 held good news for Illinois physicians.

"We need to move now – despite the opposition of some special interests – to change laws in the product liability and medical malpractice areas," Edgar said. "We can and should compensate victims. But the tort system today is out of whack, needlessly draining profits from business, boosting prices for consumers and limiting access to physicians in order to fatten the wallets of a few lawyers."

The governor also discussed

(Continued on page 22)

INSIDE

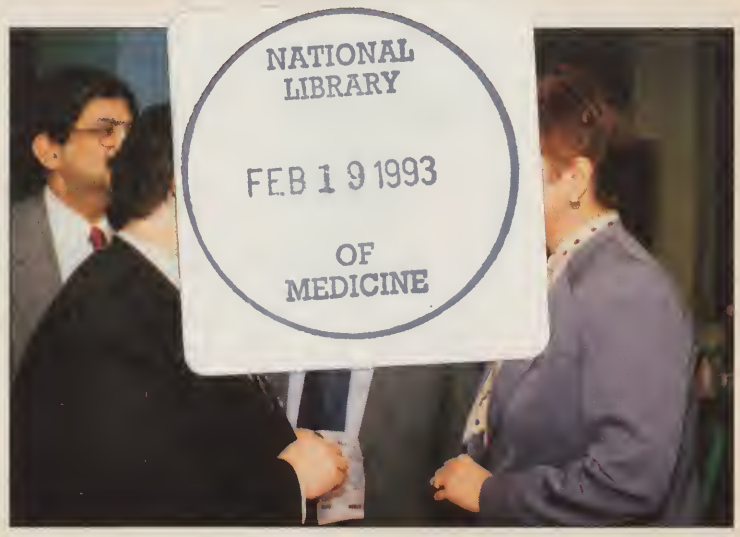


Joliet nurses strike over quality issues
PAGE 4

HCFA announces new test category, invokes COLA's inspection services
PAGE 5

DEPARTMENTS

News Briefs....2, 3
Commentary...6, 7
ISMIE Update 9
Obituaries 18
Classifieds 19



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Sen. Judy Baar Topinka, the newly appointed chairman of the Senate Public Health and Welfare Committee, answered physician questions after speaking at the Jan. 20 meeting of the Chicago Medical Society's Southwest Branch.

Legislator predicts reform

TORT REFORM: Sen. Judy Baar Topinka discusses new legislation with Chicago physicians. By Anna Brown

[CHICAGO] In her first public appearance since her appointment as chairman of the Senate Public Health and Welfare Committee, Sen. Judy Baar Topinka (R-Berwyn) told Chicago physicians about tort reform measures planned for the upcoming legislative session. Topinka lauded the new Republican majority in the Illinois Senate as beneficial for physicians, when she addressed doctors attending the Chicago Medical Society Southwest

(Continued on page 22)

Task force releases final report

RECOMMENDATIONS: Edgar's health care reform task force advises temporarily continuing the health facilities assessments. By Tamara Strom

[CHICAGO] After more than eight weeks of discussions and deliberation, Gov. Jim Edgar's reform task force suggests the state continue collecting assessments from health care facilities to help fund the Medicaid program.

The group's final report, which reached the governor's desk by the Feb. 1 deadline, stresses that the assessment program should be temporary. The group concurred that the immediate need for capturing the federal matching dollars outweighs the program's unpopularity. But the group urged the state to develop other long-range funding sources.

The recommendations spring from the group's charge – to develop strategies to combat

(Continued on page 23)

ISMS AS PATIENT ADVOCATE

BOOKLETS PROMOTE PHYSICIAN-PATIENT PARTNERSHIPS

For the past three years, the Illinois State Medical Society has sponsored the "Partners for Health" outreach program and supplied senior citizen groups and organizations with physician speakers and educational materials to help doctors communicate with their senior patients.

In their presentations, volunteer speakers are aided by patient handouts developed by the Society. Each senior is given a Healthy Partnership Kit containing six handouts with information about Medicare, patient-physician communication, helpful phone numbers of senior health agencies and a Personal Health Record.

The health record, a booklet to help patients track their own health care, is now available for physicians to distribute in their offices. "The health care needs of the senior patient are increasingly complex," said ISMS President Arvind K. Goyal, MD.

(Continued on page 23)

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Health insurers support consumer report card

[WASHINGTON] Thirty major U.S. managed health care plans have joined in developing a system that will allow consumers and purchasers of health plans to better assess the quality of care provided. In a letter to President Clinton, the group – including Aetna Life & Casualty Co., Blue Cross and Blue Shield Assoc. and Prudential Insurance Co. of America – stressed its belief that a "strong system of quality assessment is essential in light of the substantial growth in health care plans and the keen interest in health reform strategies that promote competition."

According to William Link, executive vice president for Prudential, the group's goals are to "continuously improve the quality of care provided to patients, help consumers make the best choices given their different needs and preferences, and help employers and individuals purchasing health care to get the best value for their money." The group envisions a "report card" that would measure how effectively health plans provide preventive services such as mammography and childhood immunizations and treat chronic illnesses such as asthma and diabetes, and would include surgical success rates and patient satisfaction.

The group has asked the National Committee for Quality Assurance to identify appropriate performance measures, and to develop the specifications for data collection, the audit process, and the formats for reporting performance data. The NCQA has begun developing standard performance measures and expects to complete initial measures by March. ■

IDPH establishes immunization hotline

[CHICAGO] The Illinois Department of Public Health has established a toll-free hotline to answer the public's and health care providers' questions about childhood immunizations and influenza. Hotline staff are prepared to address topics such as schedules and locations for childhood immunizations, required immunizations for schoolchildren, and recommendations for influenza and hepatitis B shots.

"There is no reason for our children to remain vulnerable to the attack of serious, yet preventable, diseases," said IDPH Director John R. Lumpkin, MD. "Ensuring children receive the proper immunizations at the proper ages is the surest method we can take to offer them an opportunity at a life free from the effects of crippling diseases."

The hotline, (800) 526-4372, is open weekdays 8:30 a.m. to 5 p.m. ■

Equal rates vs. equal rights

[BALTIMORE] The chief judge of the Circuit Court for Baltimore City ruled unconstitutional the Maryland Insurance Division of the Department of Licensing and Regulation's ban on the practice of charging men and women different premiums for the same health and life insurance policies. The Insurance Division's ban states that gender-based rate setting is "unlawful discrimination just as it would be unlawful discrimination to charge different rates for blacks, whites, Italians or Jews." The agency said that gender-based rate setting violates the Maryland Equal Rights Amendment.

The judge said the agency was out of line and only a court of law can take the action the agency did. The ruling states that differences in insurance premiums based on gender are legal as long as they are fair and actuarially accurate. In most of the United States, health and life insurance rates are higher for women due to a longer life span. Attorneys for both the National Organization for Women and the Maryland Commission on Human Relations said they will appeal the decision. ■



JUNE TAYLOR

ISMS PRESIDENT Arvind K. Goyal, MD, met with students at Marsh Elementary School in Rockford Jan. 19.

Dr. Goyal joined an assistant state's attorney to speak to fifth- and sixth-graders about the dangers of drug abuse. The presentation was part of the "Partners for Prevention" program sponsored by the American Medical Association and the American Bar Association, in cooperation with the Winnebago County Medical Society.

PMA produces AIDS survey, stroke brochure

[WASHINGTON] The Pharmaceutical Manufacturers Association has announced that for the first time, its annual survey of AIDS medicines in development has tracked clinical trials focusing on the specific requirements of women and children with AIDS. Of the 91 medicines listed in the survey as being developed for AIDS or AIDS-related conditions, clinical trials for 50 include women and 13 include children.

When the first such survey was conducted in 1987, only one AIDS therapy had been approved and was on the market. Since last year, one medicine has been approved for HIV infection, and two for opportunistic infections. Almost half the drugs currently in development are designed to treat opportunistic infections, which account for 90 percent of AIDS-related deaths, according to the PMA.

The PMA has also announced the release of the first brochure in its "Pharmaceutical Frontiers" series, "Pharmaceutical Frontiers: Research on Stroke." "We hope this publication will be useful for those who want to know more about the complexities of the disease and the potential that current research will have for saving lives and improving the quality of life for millions of stroke patients," said PMA President Gerald J. Mossinghoff.

The brochure details the two main approaches to stroke therapy and contains information about 12 stroke medicines under development, statistics about the disease and patient-support information. Free copies of the publication are available by writing to "Pharmaceutical Frontiers: Research on Stroke," PMA, 1100 15th St. N.W., Washington, DC 20005. ■

Clinton lifts 'gag rule'

[WASHINGTON] As expected, one of President Clinton's first actions upon entering the White House was to reverse the controversial "gag rule" banning health care workers from counseling patients about abortion at federally funded clinics. On the 20th anniversary of the Supreme Court's *Roe vs. Wade* ruling legalizing abortions, Clinton symbolically took action reversing several anti-abortion-related policies enacted during the last 12 years.

Although former President Bush had tempered the gag rule last fall to allow physicians to counsel patients about all family planning alternatives, including abortion, the medical community continued to petition the administration to relax the counseling prohibition for other health care workers as well. The gag rule had been in effect for only 34 days when a U.S. circuit court of appeals ruled it illegal Nov. 3 on grounds the government had invoked the change allowing doctors at Title X facilities to talk about abortion without proper public comment. That ruling seemingly opened the door for Clinton to keep his campaign promise to strike the rule.

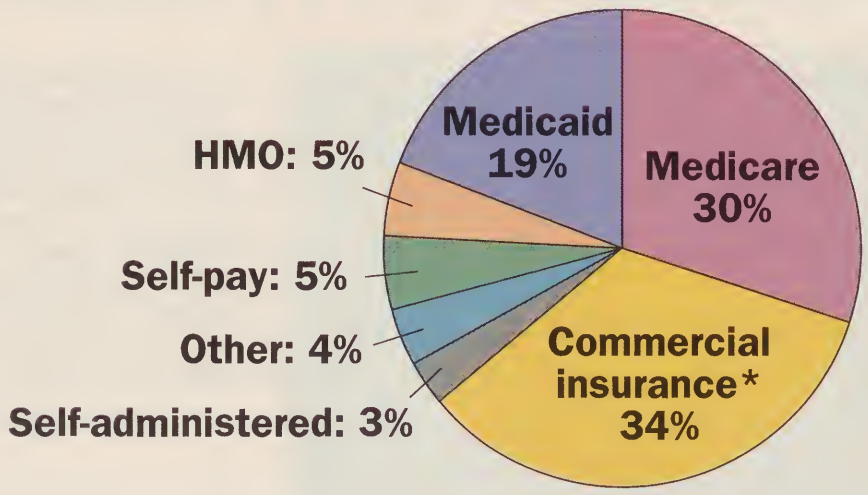
Clinton also reversed the ban on abortions at military hospitals (although women will have to pay for those services) and struck the prohibition on fetal tissue research. In addition, the president instructed the U.S. Food and Drug Administration to re-examine its import ban on RU486, the French-manufactured "abortion pill." The drug still awaits FDA approval.

In other health care actions, Clinton named First Lady Hillary Rodham Clinton to head his health care advisory task force. ■

PHYSICIAN FACTS

Inpatient insurance coverage in Illinois

Nearly half of all 1991 admissions to Illinois hospitals were for patients enrolled in government-funded health insurance programs.



Source: Illinois Health Care Cost Containment Council
*Includes self-insured plans administered by a commercial insurance company

Study shows ranks of working uninsured growing

[WASHINGTON] According to a report released by the Employee Benefits Research Institute, nearly 80 percent of America's uninsured are employed or dependents of employees. EBRI's report "Sources of Health Insurance and Characteristics of the Uninsured" shows the

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nation's nonelderly uninsured population increased 12.4 percent from 1988 to 1991, and the percentage of Americans covered by group health care plans has steadily declined over the past several years. Among the uninsured in 1991, 28.8 million, or 79.3 percent, were workers or their dependents; 6.2 million were nonworking adults; and 1.2 million were children of nonworking adults.

Bill Custer, director of research at EBRI, said the ranks of working uninsured Americans likely will continue to grow, as small companies drop their group health plans because of soaring rates.

The report is based on data collected by the U.S. Census Bureau for its March 1992 Current Population Survey and focuses on the nonelderly because of the variety of health plans available to this group. ■

$2.5 million in grants targets drug users

[SPRINGFIELD] About $2.5 million will be spent to teach Chicago-area drug abusers how to avoid becoming infected with AIDS. Gov. Jim Edgar said the state cannot afford to be passive with drug abusers because needle sharing and sexual activity make them the fastest growing group at risk for HIV infection.

Three Chicago social service agencies will receive three-year grants financed by the federal Center for Substance Abuse Treatment Grants. The Treatment Alternatives for Special Clients will be given $564,771 in federal funds and a $95,250 state grant to work with prisoners in Cook, Kane, Kankakee and Will counties. Cook County Hospital will receive $976,113 to work with patients in its emergency room and the obstetrics/gynecology department. The University of Illinois at Chicago AIDS Outreach Intervention Project will be granted $908,778 to work with drug users in the Austin neighborhood on the West Side. Twenty-two percent of the 8,022 reported AIDS cases in Illinois are among people who inject drugs. ■

Drug may prevent alcoholic relapse

[PHILADELPHIA] A prescription drug that reduces alcoholics' craving may help prevent relapse, according to two independent studies.

When combined with behavioral treatment, the drug naltrexone reduced alcoholic relapse to 23 percent, as opposed to a 54-percent relapse in participants receiving normal treatment, according to a study reported in *The Archives of Psychiatry*.

Naltrexone is widely prescribed for narcotic addicts to reduce their drug craving, but it also seems to reduce an alcoholic's craving to drink, said Joseph Volpicelli, MD, a psychiatrist at the University of Pennsylvania, who conducted one of the studies. The drug was found to interfere with the "high" brought by alcohol.

In the second study, conducted at Yale University, only 39 percent of the patients taking naltrexone relapsed, in contrast to 79 percent of those receiving counseling.

Both research groups stressed that the drug alone is not a cure and must be supplemented. That caution was underscored by Richard Fuller, MD, director of the National Institute on Alcohol Abuse and Alcoholism, who said, "I'd be careful about immediately applying the medication. The final word isn't in yet." ■

Monitoring system detects barrier failure

[SAN DIEGO] A product recently cleared for sale by the U.S. Food and Drug Administration could revolutionize surgical protection procedures for physicians. The barrier integrity monitor system, manufactured by InCoMed of San Diego, is being promoted as a device that can significantly reduce the risk of infection from transmission of bodily fluids during surgery.

The alarm system consists of a series of conductive floor mats wired to a monitor that detects very weak currents transmitted when fluids pass through gloves or gowns. Physicians stand on the mats wearing conductive shoe covers, and the patient is also wired to the monitor with a standard ECG lead.

InCoMed claims the product can detect holes in defective latex gloves as small as 30 microns in diameter and helps protect surgeons from such fluid-borne pathogens as HIV, staphylococcus and hepatitis B and C viruses. The system transmits audible and visible warnings when fluid transmission occurs, allowing gloves or gowns to be replaced immediately.

In clinical trials, the system detected 49 glove failures in 20 operations. None of the surgeries was completed without at least one glove failure. ■

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REPORT FOR *Illinois Physicians*

THE CPT AND YOU

(This article is reprinted from the Viewpoints of the Medicare B Medical Director, published in July, 1991. The author, Charles Henderson, M.D., is the Medicare Part B Medical Director in Illinois.)

The perfect world for Medicare Part B occurs when all claims submitted by providers have the correct name and number of the patient, the provider, the referring provider, the diagnosis and procedure codes, and date and place of service, either on paper claims or preferably by electronic media. The claims would then be entered into the computer system, and two weeks later a check is mailed to the provider or the patient, literally untouched by human hands. But this is not the case. Claims with errors in the above items are suspended by the computer and require manual review and necessary investigation or corrections to make the claim payable. All carriers have hundreds of clerks, claims processors, and claims examiners to handle this workload. With 1.6 million claims a month or 70,000 plus claims per workday in Illinois, your claim may not receive the personal attention you believe it deserves.

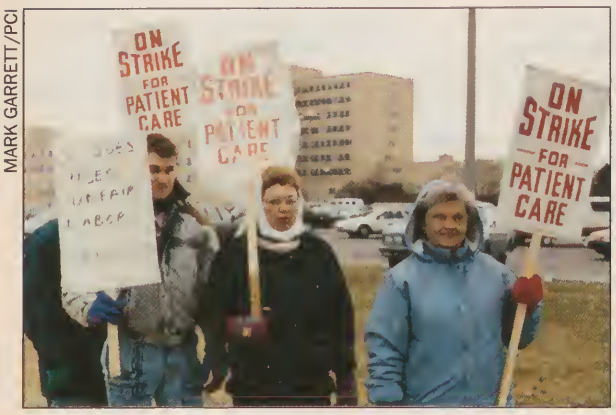
The Physicians' Current Procedural Terminology (CPT), developed and updated each year by the AMA's CPT Panel is Medicare B's guide to identify most of the procedures performed by physicians and other health care providers. Another guide has been developed by HCFA for other services, supplies and equipment covered by the Medicare program. It is called the HCFA Common Procedure Coding System (HCPCS) and includes ambulance service, injections, drugs, oxygen, supplies, equipment, and unusual procedures not contained in the CPT. Generally, there should be no overlap between CPT and HCPCS codes. Members of the CPT Panel have appeared before the Medicare Medical Director's Conferences and we are impressed that they are doing a terrific job and that it is a full-time effort just to keep up with new procedures and technology.

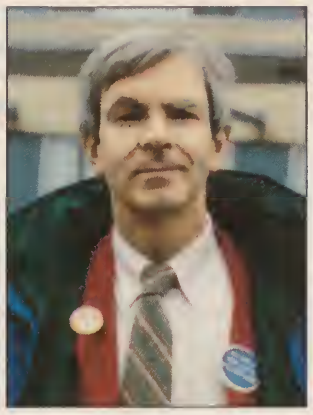
Medicare Part B's primary problem with claims is miscoding by the providers and their billing personnel. According to my non-double blind study, 54.3% of physicians and allied health providers have never looked inside the CPT. They only wish to practice their profession and leave the technicalities of coding to non-medically trained people. Our computer can read letters and numbers, but so far, has not been able to read the narrative description of the procedure performed.

All physicians and other practitioners should read through the introduction of the CPT, especially the section on levels of service for office, home and hospital visits, as well as the sections of the volume related to their specialty. Wait a week, then read it again. You, and only you, as captain of the ship, are responsible for what your billing personnel put on the Medicare claim form. Among the common errors, leaving off codes for secondary procedures on the claim forms is frequently found. In some instances, the provider did not include a secondary procedure in the title of operation on the operative report although it is well documented in the narrative of the operation performed. Remember, your billing clerk only looks at the title of the operation when completing the Medicare claim form, and almost never reads the narrative. This applies especially to physicians who may be supervising surgical residents in a teaching hospital setting.

(2/12/93)

MARK GARRETT/PCI





More than half of Joliet's St. Joseph's Medical Center nurses (above left) spent the past few weeks walking the picket line. J.D. Wright, MD (above right), said patient care has not suffered during the strike.

MDs maintain quality care during Joliet nurses' strike

DOCTOR REACTION: Will-Grundy County physicians call dispute a no-win situation. By Tamara Strom

[JOLIET] Nearly two weeks into a nursing strike at Joliet's St. Joseph's Medical Center, several area physicians said patient care is not suffering.

"Physicians are trying to maintain the highest-quality care for patients, and we're setting the standard for that [during the strike]," said Ted Kanellakes, MD, chairman of the Will-Grundy County Medical Society Communications Committee. "But how it will affect patient care if the strike goes on longer is another issue."

Both medical and surgical care at St. Joseph's is continuing unimpeded by the strike, said Joliet internist J.D. Wright, MD. "I haven't had any problems or received any complaints from my patients or their families."

Mohin Samaraweera, MD, a Plainfield general practitioner, said none of his patients have been neglected at the hospital. "I still admit my patients to that hospital. I'm quite satisfied with how the hospital is administering the care."

At the beginning of the strike, physicians had "some fear" that there might be "problems, deficiencies or screwups, but that hasn't occurred fortunately," Dr. Wright said.

The consensus of physicians is that the strike is a no-win situation, Dr. Kanellakes said. "It's not healthy for the community. Even though quality of care has not been affected as yet, it does mar the community. It affects our image."

NEITHER THE MEDICAL SOCIETY nor the hospital's medical staff has taken formal positions on the strike; both have elected to remain neutral, Dr. Samaraweera said. St. Joseph's medical staff members generally understand the positions of the nurses and the hospital administration, Dr. Kanellakes added. In fact, many physicians at one time or another have shared some of the nurses' concerns about quality of care issues, particularly the hospital's "pulling" policy.

If the census in one area of the hospital decreases, the nurses are either sent home or transferred to another department that has more patients, he explained. For example, a pediatric nurse could be assigned to work the emergency room or intensive care unit. "[The nurses'] point is, 'Don't send us into any area where we don't have any experience,' " he noted.

Dr. Kanellakes said he believes the new hospital administration (which took over shortly after the hospital's RNs voted to unionize in December 1991) has shown "consistent credibility, sincerity and accountability" and will work to end the strike. "But we understand that with the union it makes the situation more complex and makes it difficult for an easy resolution," he said. "There are federal laws [governing negotiating] that must be followed."

> *Physicians are trying to maintain the highest-quality care for patients, and we're setting the standard for that. But how it will affect patient care if the strike goes on longer is another issue.*
>
> **TED KANELLAKES, MD**

ALTHOUGH MOST PHYSICIANS support the nurses' right to strike, Dr. Kanellakes said some of the strike tactics used the first few days of the strike were questionable. Joliet is a union town, and the striking nurses were joined on the picket line Jan. 18 by other sympathetic unions, such as the electrical workers and Teamsters. "It was a riot climate," he said, explaining that people were obstructing the hospital entrances, making it difficult for physicians and other nonstriking employees to get to work. Outpatients and visitors for inpatients also had trouble entering the hospital.

"Their concept of a strike is different," Dr. Kanellakes said of the other unions. "I don't think the striking nurses had any idea. You can demonstrate to express your dissatisfaction. But you can't strike the same way you can at Caterpillar when you try to shut it down. We don't think you should impede physicians and other people from trying to get into the hospital to provide care. You don't use patients as hostages or pawns. That upset us."

A court injunction, however, limited each side to only five protesters at each hospital entrance.

Dr. Wright said most physicians have maintained amiable relationships with the striking nurses. In fact, his office is just a block from St. Joseph's, and when he walks over to do rounds every morning, he typically chats with some of the nurses as they walk the picket line.

Some doctors are concerned about an adversarial climate that might exist within the hospital once the strike concludes, Dr. Kanellakes said. In particular, he is worried about the relationships between the striking nurses and the nurses who chose to return to work and nonunion employees who crossed the picket line. "We hope any differences of opinion could be respected and that grudges, animosities or hostilities that existed [during the strike] will be forgotten so we can all go on with patient care." ■

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

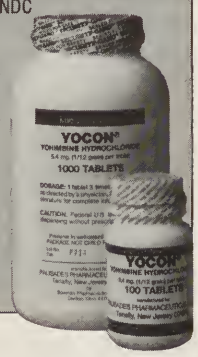
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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HCFA announces new test category, invokes COLA's inspection services

CLIA: A new microscopy category gives physicians greater testing latitude. By Anna Brown

[WASHINGTON] The U.S. Health Care Financing Administration is recognizing a difference in ability between physicians and nurses or lab technicians by introducing a new test category under the Clinical Laboratory Improvement Amendments of 1988. For the first time since CLIA's inception physicians will be given latitude to personally conduct certain diagnostic microscopy procedures in their offices, eliminating the need to hire additional technical staff. This provision is in addition to the simple test category, which does not require application for a registration certificate.

The new category is subject to all conditions of moderate-complexity tests, except that laboratories performing only these and waived tests will not be subject to routine inspections. Inspections will be made, however, in response to public complaints. Participating physicians will be responsible for basic quality control, as proficiency programs do not exist and are unlikely to be developed. The tests included in the category are

- Wet mounts, including preparation of vaginal, cervical or skin specimens;
- All potassium hydroxide (KOH) preparations;
- Pinworm examinations;
- Fern tests;
- Post-coital direct, qualitative examinations of vaginal or cervical mucus;
- Urine sediment examinations.

Physicians will be given latitude to personally conduct certain diagnostic microscopy procedures in their offices, eliminating the need to hire additional technical staff.

The cost of a certificate for the new category is $150, and HCFA has indicated that physicians will not be required to obtain both the waiver and microscopy certificates. It is anticipated that physicians who have purchased a $100 waiver certificate or moderate-complexity certificate will need to pay only the difference to obtain the microscopy certificate.

HCFA has also added HemoCue and other single analyte hemoglobin tests to the waived category.

PHYSICIANS WHO HAVE office laboratories and who are trying to comply with CLIA have an alternative to the federal government's inspection, according to the Commission on Office Laboratory Accreditation. They can participate in the HCFA program, which requires a biennial on-site inspection, or obtain accreditation from a HCFA-approved, private, nonprofit, peer-reviewed accreditation program. COLA is a voluntary, nonprofit accreditation and education program for physician office laboratories.

"Seeking COLA accreditation can be more cost-effective than the Health Care Financing Administration's inspection process," said Stephen Kroger, MD, COLA chief executive officer. For example, he said, a two-physician practice performing 12,000 tests per year in four specialties of testing will pay COLA a biennial fee of $1,200, the additional $100 HCFA biennial certification of accreditation fee, and the $82 validation fee, for a total $1,382. This compares to the HCFA inspection fee of $1,645 for the same period.

According to COLA officials, HCFA recently said laboratories currently enrolled in the COLA program and those that intend to obtain a "certificate of accreditation" on the HCFA-116 form will not be billed for an inspection, nor listed for inspection by state and federal surveyors. Since the Illinois General Assembly repealed the Illinois Clinical Laboratory Act in the last session, Illinois physicians who do testing in their office labs are subject to the federal regulations.

COLA officials caution that their program is not a substitute for proficiency testing and that physicians with office labs must still purchase a proficiency testing package from an approved proficiency testing program.

Interested physicians can get more information about the COLA program by calling (301) 588-5882. ■

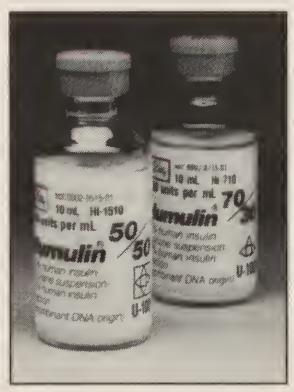
– Kevin O'Brien contributed to this story.



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EDITORIAL

Good news

Who says there's no good news? Six years with no dues increase – now that's great news. The Board of Trustees recently approved retaining the current dues structure through the 1994 membership year.

The benefits of membership in an organization aren't always this obvious. But they do exist, nevertheless, for members of the Illinois State Medical Society. One outstanding benefit for all our physician members is advocacy in the political and legislative arena.

Take tort reform, for instance. In this issue are pledges from Gov. Jim Edgar and Sen. Judy Baar Topinka to aggressively pursue tort reform in the upcoming legislative session – specifically, a cap of $250,000 on noneconomic damages in malpractice cases. Another bill would limit punitive damages in product liability suits, an area directly related to the profession and medical research. This type of aggressive advocacy is vital.

In his state of the state address, Gov. Edgar said: "We need to move now – despite the opposition of some special interests – to change laws in the product liability and medical malpractice areas. We can and should compensate victims. But the tort system today is out of whack, needlessly draining profits from business, boosting prices for consumers and limiting access to physicians in order to fatten the wallets of a few lawyers."

A recent article in *The Wall Street Journal* presents findings from a study published in the *Applied Economics* journal. The study found that when other sources of lawyers' incomes evaporate or as competition increases, attorneys pursue more medical malpractice claims. And the worse business gets, the more likely lawyers are to take weak cases they would otherwise avoid.

One of the study's authors said: "As you get more lawyers relative to the business available, the value of their time declines. As that value declines, then the previously unattractive cases become more attractive."

The study states that legal business in a given community can support only so many lawyers, depending on variables such as income and the number of crimes and divorces in that community. Any "excess of lawyers" over the specified number "would seek out other opportunities, albeit at lower expected values, to earn money," the study said.

If plaintiffs' lawyers are "out there trying to expand the market for their services, these enormous unnecessary costs are just increasing exponentially," said the president of the American Tort Reform Association.

The study concluded that a 10-percent increase in lawyers' excess time drives up the number of medical malpractice claims 4 percent.

With statistics like that, reform in our civil justice system is essential. And your medical society is ready and willing to tackle that goal.

PRESIDENT'S LETTER

Where there is smoke, there is fire

By Arvind K. Goyal, MD



It is hard to accept that board actions, wrong or right, couldn't be peer reviewed.

A folk tale tells of a man who informed a friend he was going into business. "What sort of business?" the friend queried. "A partnership," was the reply. "Are you putting in much capital?" "No, we have a different arrangement. We go into business for three years. He puts in the money, I put in my experience. At the end of three years, I will have the money, and he will have a lot of experience."

What I'm hearing from hospital medical staffs around the state indicates many physicians are getting more experience than they thought they deserved.

That credentialing of medical staff now starts with a pre-application at many hospitals. A young physician, board certified in his specialty, just out of a residency, without much of a record – good or bad – living and practicing in the same community as the not-for-profit community hospital built with donations from the community, was denied an application after he submitted a four-page pre-application. Was that fair? He suspected that happened because he had simultaneously applied to three hospitals, the other two being competitors. He was told their bylaws did not allow any review of their actions on pre-apps!

Several established cardiovascular surgeons complained when "their" hospital signed up for their newly approved cardiac surgery program with a local university group – who were coming in on an exclusive basis for a seven-year period. These surgeons, the hospital let them know, had no automatic right to such privileges. It didn't matter that they had impeccable credentials, excellent track records and privileges to do cardiac surgery at other area hospitals; some of them even had teaching appointments at other institutions.

And more recently, at another community hospital, three groups of cardiovascular surgeons were "summarily" excluded from continuing to perform cardiac surgery, at two-weeks' notice, the result of an "administrative decision" by the hospital board to enter into an exclusive contract with an outside group. Requests for peer review were denied. The quality of their work was not in question – they had ably served the needs of their patients in the hospital up to that point. But now the times were changing! The medical staff or its committees couldn't review this matter – it wasn't within their purview. And the board's concern for the well-being of the affected physicians showed when they announced their action would not be reported to the Data Bank!

In our society where there is increasing public scrutiny of everything else, it is hard to accept that board actions, wrong or right, couldn't be peer reviewed. That the courts have ruled hospital boards can do what they want, as long as medical staff bylaws are not violated, isn't good enough. Bypassing the medical staff bylaws without actually violating them is serious enough.

Lest somebody believes it is a problem unique to cardiovascular surgeons, be informed that everybody is "at risk." It has happened to physicians reading EKGs, those giving anesthesia, even those working in hospital-owned clinics and buildings. Some were let go because they couldn't attend required meetings at the hospital. Some family practitioners and internists received a "cold shoulder" because they hadn't admitted enough "warm bodies" to the hospital the previous year.

Physicians at one hospital received profiling data marked "confidential" from their administrator comparing their utilization parameters against others. So, if I brought in more uninsured, public aid, or AIDS or other sicker patients, my reappointment could be in jeopardy. When available, the options of hearings, reviews and lawsuits remain very tedious, time-consuming and expensive. Admitting or operating privileges at a second or a third hospital could ease the pain while waiting, something hospitals like less and less.

A recently enacted rule by a hospital radiology group would allow firing of any member of the group, by a majority, at a 90-day notice. Since the group enjoys an exclusive long-term contract with the hospital, a member in practice for 10 or 20 years with that group could be on the street without a fair shake or due process available to all other members of the medical staff.

Some hospitals are now trying to transfer quality assurance functions from medical staffs to board committees, medical directors or equivalents hired by the board, some of whom may never have practiced medicine. Is that peer review?

The hospital medical staffs need to be ever vigilant in opposing so-called economic credentialing. Exclusive contracts by hospitals in areas of clinical practice ought to be discouraged. Independent attorneys who are not in conflict by working for the hospitals should be retained for review of medical staff bylaws.

Credentialing and re-credentialing based on economics, productivity, budgeting, control and any factor other than credentials and quality of work is "dangerous" for physicians and also our patients, who lose the benefits that come with choices, continuity of medical care, competitive pricing and sometimes convenience. A hospital or other entity that manages to ignore, bypass or violate the rights of its medical staff cannot be trusted to protect the health and rights of the patients it purports to serve.



GUEST EDITORIAL

The health swamp

By Eli Ginzberg

The Clinton Administration will soon find out why health care reform is so difficult. The reason is that for most people, the health system is satisfactory.

Although about one in seven has no insurance, most of the uninsured are children or young adults, who use physicians and hospitals rarely. Another one in seven, on Medicaid, is likely to receive less than optimal care, but deficiencies also characterize his or her housing, income, food and education. A further one in seven may face serious trouble when confronting catastrophic illness or injury because of shallow insurance coverage.

About two in three with good private health insurance or who are on Medicare are well covered when they need acute care. Many are too well covered because the $65 billion annual tax subsidy for private health insurance enables upper-income employees to obtain more and better health insurance coverage than they would buy with after-tax dollars.

Moreover, the affluent elderly get more benefits from Medicare than they contributed in taxes or premiums, especially Medicare Part B (payments to physicians). Somewhere along the line, Congress reduced the charge to beneficiaries from 50 percent to 25 percent of the annual cost.

In any case, the government subsidizes the more affluent sectors of the population, below and above 65, to the tune of about $85 billion annually. Any sensible reform will have to end part of this subsidy if Congress is to move toward coverage for everyone.

In 1980, America's total health care expenditures amounted to $250 billion. Today, the figure will be in the $810 billion to $820 billion range. What's the rush for reform if the United States was able to increase its health care financing by $560 billion in the short span of 12 years? Moreover, we are on our way to piercing the trillion-dollar level by 1995.

The 9 million people employed in health care have no serious complaints. Physicians on average earn about $165,000 a year after expenses but before income taxes. Most of the 5,200 acute-care hospitals still operate in the black even though their average occupancy is low.

Despite national stagnation in jobs and income, the health care sector stands out with more job holders earning more in wages and fringes. Medical schools have enjoyed a doubling in revenues, from $10 billion to $20 billion, during the past decade in the face of a 2-percent increase in the undergraduate student body.

The continuing flow of additional dollars into the health care system has kept reforms on the back burner, but that era is coming to an end, and soon. We need to find a *second* trillion dollars between 1995 and the year 2000 to keep the system on its present trajectory. That translates into an outlay of $30,000 for health care in 2000 for a family of four – more than the family will have spent on food, clothing, housing and transportation *combined* in 1990. The second trillion will not be findable.

The private health insurance industry is covering fewer Americans today than in the early 1980s, and it spends much effort identifying high-risk persons to avoid insuring or reinsuring them. In addition, governors have petitioned Congress and the president to call a halt to the government's adding new mandates on the states to broaden Medicaid coverage.

Employers say health care costs must be moderated if the U.S. is to regain its competitive position in the world economy. Workers face increasing pressures from employers to cover more of their insurance premiums.

The best way to summarize where we are, and are going, is to recall what Dr. C. Everett Koop, the former surgeon general, said: We are in crisis and not much will happen until we enter chaos.

Eli Ginzberg directs the Eisenhower Center for the Conservation of Human Resources at Columbia University.

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GUEST EDITORIAL

Calling Dr. Doctor

By Howard J. Bennett, MD

A few months ago, I read a funny article about people who take poetic license with their use of the title "Doctor." In his travels through the phone book, the author found not only a "Pet Doktor" and a "Bike Doctor," but he also discovered someone who billed himself as "The Rug Doctor."

After reading this article, I began thinking about the humorous implications of people's names. For example, although Joseph Heller created a fictional character named Major Major in his novel *Catch-22*, there actually are physicians in this country named Doctor (18 to be exact). Realizing that this was probably just the tip of the iceberg, I decided to find out how far this Dr. Doctor thing might go. So, with pen in hand, I spent a weekend flipping through the 1990 edition of the *American Medical Directory of Physicians in the United States.*

> *There are 22 doctors in the United States named Needle, Probe, Lance and Ligate.*

The first thing I learned during my research is that there are a lot of doctors in this country. Although I did not get page turner's tendonitis, I did need a stiff drink by the time I reached the Zs. I also learned that doctors' names often bear an interesting relationship to what they do for a living.

There are 22 doctors in the United States named Needle, Probe, Lance and Ligate. Not to be outdone by such simple procedures, there are another 20 named Drill, Scope, Bolt and Pin. I couldn't find anyone named Cut or Clamp, but there are three doctors named Drain.

Many doctors have names that are more generic and, I might add, quite appealing from the patient's point of view. I found 19 physicians named Fix, Cure or Heal. If any of them formed a group with those named Brilliant (6), Able (6), or Best (62), there's no telling how popular their practice might be. It goes without saying that they would have a clear advantage over the 9 doctors named Klutz, Croak, Blunt and Blewitt.

Doctors' names often say a lot about the type of medicine they practice. I found a dermatologist named Rash, a rheumatologist named Knee, and an orthopedic surgeon named Bone. My favorites, however, were a psychiatrist named Couch and an anesthesiologist named Gass. Nevertheless, a doctor's name does not always correspond with his or her specialty. There are 10 doctors named Blood, but none of them are hematologists. Similarly, of 11 doctors named Dust, Mold and Pollen, none are allergists. I also discovered a handful of doctors name Eye (3), Nose (2), Tongue (2), Kidney (1), Stool (4), and Surgeon (1), none of whom work in the area suggested by their name. The best in this category belong to Drs. Briss (1) and Stream (4), who, I'm sorry to say, are not urologists.

Sometimes a doctor's initials can be more revealing than his name. I found an obstetrician with the initials R.O.A., a cardiologist with the initials E.C.G., and a neurologist with the initials C.N.S. There is also a surgeon out there who can sign his orders N.P.O. On the other hand, there are no internists with the initials F.U.O., and I couldn't find anyone, not even a pathologist, with the initials Q.N.S.

Given my affiliation with a medical center, I was interested in those names that had an academic ring to them. Although I didn't find anyone named Publish, there is a physician in this country named Perish. This is fitting, I suppose, because I couldn't find anyone named Tenure either. I did find lots of Grants, however, something my colleagues say are in short supply these days. I also found 3 Deans, 1 Teacher and 48 doctors named Pearl. Given that medical students often complain about their preceptors, the abundance of Pearls seems to balance out the 20 doctors named Bicker, Gripe, Fuss and Grill.

Some doctors have names that might create a little confusion in the places where they work. Imagine what people think when an operator pages Dr. Page (140) or when the ER puts in a stat call for Dr. Stat (1). How would patients react if they shout "Nurse!" and Dr. Nurse (3) is the one who shows up as they're fumbling with their bedpan? Other names that probably raise a few eyebrows from time to time include the 65 doctors named Flesh, Gore, Ache and Looney. Finally, should you develop chest pain in the middle of the night, whom would you rather meet in the emergency room, Dr. Code (5) or Dr. Crump (29)?

It was amusing to note what would happen if particular doctors got together either as co-authors on a paper or as colleagues in an office. Possible combinations include Vital (2) and Signs (1), and Brain (1) and Stem (5), as well as the more interesting Laurel and Hardy (4), and Abbott and Costello (46). I also found 61 doctors named Marx, though I couldn't determine if any of them are brothers.

The next time you send in a check to cover your escalating malpractice insurance, consider the irony in this: There are 43 doctors in the United States named Judge or Jury. I couldn't find any Attorneys, but that shouldn't be a problem since they never have any trouble finding us.

If all this is giving you indigestion, perhaps you should give your own doctor a call. However, if his name is Placebo, just take some Maalox and call it a night.

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This man was involved in 42,000 surgeries last year.

And yet, he's not a physician. He works for a third-party payer. And in a typical year, he reviews over 42,000 medical procedures and treatments.

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ISMIE Update

Malpractice Roundup
PAGE 10

Exchange Board Briefs
PAGE 11

Defense attorney offers deposition tips

LITIGATION PROCESS: Physicians attending a recent Chicago Medical Society meeting learned how to begin defending a malpractice suit. By Anna Brown

[CHICAGO] Don't practice medicine. That's the only way to stay out of a malpractice suit, according to one defense lawyer.

"If you have any assets, you are subject to being sued," said Kevin Glenn, a defense attorney and partner with the Chicago firm Clausen, Miller, Gorman, Caffrey & Witous. Glenn spoke to physicians attending the Jan. 20 meeting of the Chicago Medical Society Southwest Branch at Holy Cross Hospital on Chicago's Southwest Side. Glenn's remarks addressed the deposition process rather than specific company parameters.

Glenn said that preparation is the key to giving a successful deposition. He urged physicians to listen to their lawyers.

When called for a deposition, physicians should first understand why they are being deposed and what the charges are, explained Glenn. They should also be thoroughly familiar with all pertinent medical records. "It is axiomatic that you must virtually memorize your own records," he said, giving attendees the strong impression that a case could be lost if physicians are unable to read their own handwriting.

EVERYTHING A PHYSICIAN can do to prepare can be significant, even reviewing the case's certificate of merit. The certificate of merit statute was created to help weed out frivolous suits, but some doctors will sign an affidavit whether or not it has merit, Glenn warned. However, the certificate can be used by the defense early in proceedings to determine the course of the plaintiff's argument. "The certificate of merit is often the rubber stamp of the lawyer's view of the medical problem. By looking at it you can get a good idea of where the theory is going to go."

Attending other depositions is a good way for physicians to prepare for their own depositions because they will know what to respond to, Glenn said.



WM. DANIELS/THE PHOTO PARTNERS

Kevin Glenn, a Chicago-based defense attorney, spoke at the Chicago Medical Society Southwest Branch meeting Jan. 20.

"Understand what a deposition is," he told the group. "The concept is always the same." To better prepare physicians to be deposed, attorneys can even stage a mock deposition, which can be videotaped and critiqued. Physicians should also attend plaintiffs' depositions.

"Doctors are much better at being prepared than they are at listening to their lawyers," Glenn remarked. "Don't tell me how to be a lawyer. Lawyers are working very hard to bring you competent legal help."

THE BEST WAY PHYSICIANS can use their attorney's services is by finding out what the defense strategy will be. By learning the overall defense plan, physicians will know how they can help and where their weak points will be, he explained.

Glenn cautioned that when being deposed, physicians should not attempt to "play lawyer. Answer the question posed and don't offer information. If the plaintiff's attorney doesn't ask good questions, too bad for him."

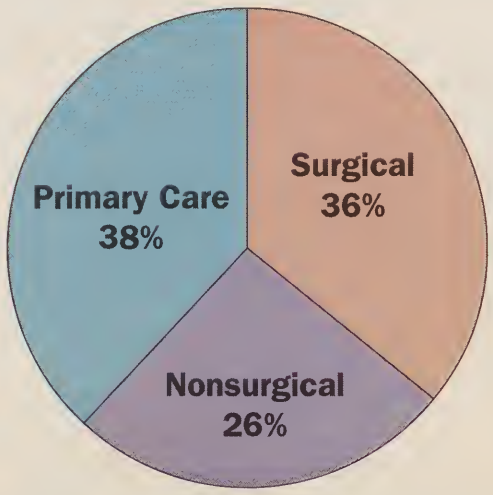
Another reason for answering the question posed as simply as possible is that defendants are locked into the answers they give. "If a jury hears that you answered differently in the trial than in the deposition, you will seem dishonest," Glenn said. In depositions, plaintiffs' attorneys often use catch phrases that can be used against defendants during the trial. Such seemingly simple questions as, "Wouldn't you agree that ...?" can be troublesome. "We're never going to agree," Glenn said. "Even if you do agree, give it back in your own language."

GLENN ADVISED PHYSICIANS to listen to the objections. "Objections are meant to teach you. We're trying to clue you in."

Finally, physicians should ask for a post-deposition review. "Ask for a candid evaluation and don't expect it to be sugarcoated. The plaintiff's attorney will do the same thing in the trial, so ask for a candid evaluation and take it."

The Exchange risk management department offers for loan the videotape "The Physician Defendant: Your Deposition" as part of its video library. The video explains in detail the purpose of and preparation for the deposition, including a case history illustrating some pitfalls of being unprepared. The video "The Physician Defendant: Your Trial" is also available. Physicians may obtain copies of the videos, which are accompanied by handbooks, by calling the risk management department at (312) 782-2749 or (800) 782-ISMS. ■

Breakdown of active ISMIE policyholders*



* As of Sept. 30, 1992. Nonsurgical also includes physicians who are retired, not practicing or practicing in a nonstandard specialty.
Source: Illinois State Medical Insurance Services.

Physician pinpoints common misadventures

[CHICAGO] Jere E. Freidheim, MD, chairman of the Illinois State Medical Society Board of Trustees, emphasized the importance of minimizing errors that can lead to malpractice suits when he spoke at the Jan. 20 Chicago Medical Society Southwest Branch meeting. Physicians also learned the importance of communication among all parties involved in the defense of the case, including their defense attorney and their malpractice insurance company.

Dr. Freidheim, who is also chairman of the Illinois State Medical Inter-Insurance Exchange's Risk Management Committee, highlighted several common problems that can result in loss, called misadventures. He listed the top misadventures that can cause suits:

- Erring in diagnosis;
- Performing a procedure improperly;
- Delaying performance of a procedure;
- Failing to recognize a complication of treatment;
- Failing to supervise or monitor care;
- Performing nonindicated or contraindicated procedures, or failing to use a more appropriate alternative;
- Prescribing medication improperly;
- Failing to instruct or communicate with a patient;
- Leaving a foreign object in a patient;
- Failing to perform indicated procedures.

Physicians who are sued should maintain close contact with their malpractice insurance company to ensure the best possible defense of their suits. They should also attend all depositions.

Dr. Freidheim also presented an overview of current Exchange programs and services available to policyholders. These include a variety of seminars, videotapes and brochures to help physicians and their office staffs prevent losses and manage risk. A risk management self-study program is also available to physicians. The Physician Support Group, a network of physicians and their spouses who have experienced the litigation process, provides support for physicians who are facing malpractice suits and for their families.

Exchange policyholders are reimbursed for each day spent at depositions other than their own. For more information about the Defendant Reimbursement Program, contact the Exchange at (312) 782-2749 or (800) 782-ISMS. ■

HIV testing and bloodborne pathogens



A physician has virtual autonomy when making the decision whether or not to test a patient for the HIV. A number of physicians use this to allow them to obtain pretreatment permission to test for the HIV. If the patient refuses to submit to the test, the physician may then treat the patient as if that patient is noncooperative and, on that basis, follow the guidelines for procuring alternative care. In addition, various hospitals have additional staff requirements.

Specifically, according to the AIDS Confidentiality Act, Ill. Rev. Stat. 1991, ch. 111 1/2, pars. 7301–7316, a physician does not have to have written informed consent for HIV testing of a patient:

1) When a health care provider (or a health facility) uses a human body part donated pursuant to the Uniform Anatomical Gift Act, or if semen is provided for the purpose of artificial insemination and such a test is necessary to assure the medical acceptability of such gift or semen (see Id., par. 7307 sec. 9(a)).

2) To perform a test when a health care provider or employee of a health facility, or a firefighter or an EMT-A, EMT-I, or EMT-P, is involved in an accidental direct skin or mucous membrane contact with the blood or bodily fluids of an individual that is of a nature that may transmit HIV, as determined by a physician in his medical judgment. Should such test prove to be positive, the patient and the health care provider, health facility employee, firefighter, EMT-A, EMT-I, or EMT-P shall be provided appropriate counseling consistent with the AIDS Confidentiality Act.

3) When a law enforcement officer is involved in mucous membrane contact with the blood or bodily fluids of an individual, that is of a nature that may transmit HIV, as determined by a physician in his or her medical judgment (Id., par. 7307, sec. 9(c)).

4) For the purpose of research, if the testing is performed in a way that the identity of the test subject is not known and may not be retrieved by the researcher, and in a way that the test subject is not informed of the results.

5) When, in a physician's judgment, testing is medically indicated to provide appropriate diagnosis and treatment to the test subject, provided that the test subject has already provided consent to medical treatment.

THE FEDERAL OCCUPATIONAL Safety and Health Administration has rules regarding occupational exposure to bloodborne pathogens. The rules codify the U.S. Centers for Disease Control and Prevention's recommended Universal Precautions, which are based on the premise that health care workers should treat all blood and other body fluids as potentially infectious and habitually use specified procedures to avoid exposure to potential contaminants. The rules provide a specific basis for the delineation and enforcement of infection-control procedures:

• Employers of health care workers must develop written exposure-control plans that identify workers "whose reasonably anticipated duties" may result in exposure to bloodborne pathogens. The plan must also specify how those at-risk employees will be protected and trained.

• Employers are required to provide, free of charge, protective clothing and equipment to all employees whose duties involve potential exposure.

• When disposing of sharps or material contaminated with blood or body fluids, health care facilities are required to use nonleaking and puncture-resistant containers. Work environments that are exposed to potentially infectious materials must display warning signs.

• Employers must train all workers at risk for occupational exposures in the Universal Precautions, provide employees with access to a copy of the OSHA standard and maintain detailed records of the employee training programs.

• Employers must offer free hepatitis B vaccinations to all employees who may be exposed to blood or body fluids. The vaccination must be offered to the employee within 10 working days of that employee's assignment to exposure-prone duties. Employees who elect not to receive the vaccination must sign a written form acknowledging their declination.

• Employers must provide free post-exposure services to employees. The services are to include immediate medical evaluations, follow-up investigations, laboratory services, information on post-exposure prophylactic treatments, and counseling.

The exposure control plan was effective May 5, 1992. The provision requiring training and record keeping was effective June 4, 1992. Provisions for engineering, housekeeping, implementation of vaccination and post-exposure follow-up programs and the placement of warning labels and signs were effective July 4, 1992. ■

Editor's note: This is part of a series covering medical-legal issues written by the Illinois State Medical Society Medical Legal Council. The information addresses legal concerns that physicians most commonly express to ISMS. It is intended to serve only as a general guide for physicians, not as specific legal advice.

MALPRACTICE ROUNDUP

Hospital denied treatment over AIDS fear



United Press International reports a woman is suing a Michigan hospital claiming she was denied treatment two years ago because hospital staff suspected she had AIDS. After one of the woman's sons was infected with chickenpox, her doctor sent her to the hospital to receive an injection to boost her weak immune system. She said when she arrived at the hospital, she was questioned about why she needed the shot and whether she had AIDS or was HIV positive. She was then told the medication was not available. The woman, who does not have AIDS or HIV, eventually received treatment at a different hospital.

Seeking more than $10,000 in damages, the lawsuit is based on a Michigan Supreme Court ruling in August 1992 that discrimination based on a perception that someone has AIDS violates the state Handicapped's Civil Rights Act. ■

Malpractice fear may prompt Caesareans

Researchers from the Penn State University College of Medicine found that doctors who fear being sued for malpractice appear more likely to deliver babies by Caesarean section. As reported in the *Chicago Tribune*, the college analyzed 1984 data on 60,490 cases at 31 hospitals in New York state and found that doctors practicing in areas where the most malpractice claims were filed were three times more likely to perform Caesareans than those practicing in low-malpractice areas. The authors said that although the results do not prove the existence of defensive medicine, they do support one explanation for high rates of Caesarean delivery. ■

Juror consults AMA guide, verdict set aside

According to the *Malpractice Reporter,* a jury verdict in favor of a Massachusetts physician was set aside because one of the jurors had brought a copy of the American Medical Association's *Family Medical Guide* into the deliberation room for consultation.

The plaintiff was diagnosed as suffering from cerebral palsy, the alleged result of inadequate oxygen supply to his brain at birth. The jury found the physicians negligent, but determined that their negligence was not the proximate cause of the cerebral palsy.

At a post-trial hearing, six jurors disclosed that they had read, or had heard read, a section of text from the AMA *Family Medical Guide* regarding cerebral palsy. One juror said, "The part I remember, there was no known cause for [cerebral palsy]." The rule of law applied was that once a party has shown that the jury was exposed to extraneous material not in evidence, the burden shifts to the other party to show that the jurors were not reasonably likely to have been influenced by the material. The court concluded that a new trial was necessary, and the verdict was set aside. ■

Communicate or litigate

Medical negligence may not be the most common variable in the birth of a malpractice suit. *The Letter*, a publication of the Louisiana Medical Mutual Insurance Co., reports on a study of 100 families that had filed malpractice claims. When asked why they had sued, most respondents complained of poor physician-patient communication. *The Letter* suggests actions physicians can take to reduce liability and improve communication. They include using body language that communicates openness, encouraging patients to talk and giving them the time to do so, avoiding medical jargon, and communicating with the families as well as the patients. ■

Study attempts to quantify defensive medicine costs

The U.S. Office of Technology Assessment is conducting a study to determine the cost of defensive medicine. Composed of mainly academics and a few medical practitioners, the group spent its first two meetings arguing over the definition of defensive medicine. According to a physician on the panel some members said all tests are done in the best interests of patients, but others said that those paying the bills believe that many tests and procedures simply protect against liability and are unnecessary. As reported in *Medical Liability Monitor,* an OTA staffer said the group wants to "leave the door open" on definitions but will have to narrow its focus due to financial constraints. Congress has appropriated $100,000 for the study.

According to OTA, an interim report was to be made to the administration in January for consideration in the development of President Clinton's health care proposal. ■

EXCHANGE BOARD BRIEFS

The Illinois State Medical Inter-Insurance Exchange Board of Governors met Jan. 29 at the ISMS Conference Complex. The following are highlights of the meeting:

Exchange to study minimum limits offered

The Exchange continually analyzes the changes in society and the marketplace to ensure responsiveness to policyholders' needs. As a part of this effort, the Exchange Planning Committee will send letters to policyholders who carry the lowest available limits. The letters will include a survey regarding the reasons for carrying the minimum limits and will also outline the dangers of carrying low limits to the policyholder, other colleagues and the company.

Support seminars scheduled

The Exchange's two-hour program supporting physicians who have been sued, "Taking Control: Managing Your Malpractice Lawsuit," will be offered March 24 in Chicago, April 28 in Peoria, Sept. 29 in Oak Brook and Oct. 20 in Rockford. Policyholders will receive registration material for these programs this month.

Policyholders to elect new board members

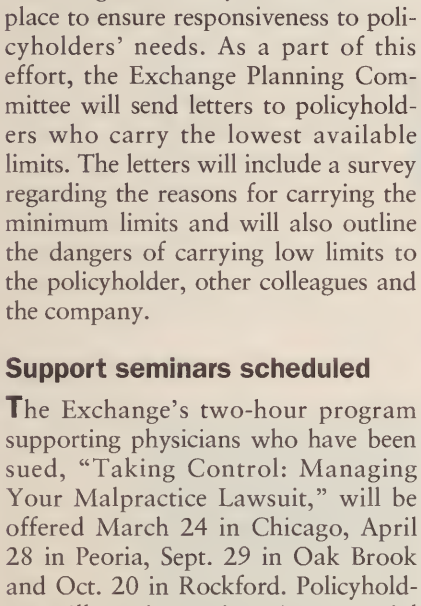
As of Feb. 19, policyholders will receive proxy ballots to vote on board members slated by the Exchange Nominating Committee. New board members will begin serving at the Exchange Annual Meeting, April 21, in Oak Brook.

Exchange reviews budget and financial plan

The Exchange's 1993 budget and financial plan incorporates the resources needed to implement its "Physician First Service" initiative, while maintaining an administrative expense ratio well below the Physician Insurers Association of America's composite median of 13.6 percent. Elements of Physician First Service include restructuring the review committee process, strengthening legal expertise through in-house legal counsel, increasing the resources for staff and board to serve policyholders, and acquiring technology to improve policyholder communications. The Exchange's financial health remains strong in the face of an uncertain economic climate and increasing average indemnity.

Network enhancement planned

Members of the ISMIE Network – physician policyholders who volunteer to represent the Exchange at their hospital – will be contacted to determine their interest in continuing to serve. A new network job description includes educating and informing current and potential policyholders about the Exchange's products, plans and activities. Exchange board members will serve as liaisons with the Exchange for network members in their area. Network members will be invited to an orientation session with the board on April 21, following the Exchange annual meeting. The Exchange will host a luncheon on April 24 for all physicians and others who attend the ISMS annual meeting of the House of Delegates. ■



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CROSS-CULTURAL MEDICINE

Lending an ear to cultural diversity

Physicians and advocacy groups recognize the need for trained medical interpreters, better communication and greater sensitivity.

BY ANNA BROWN

In mid-November 1992, a health task force formed by the Travelers and Immigrants Aid of Chicago confronted Cook County Hospital with its fears that non-English-speaking patients were not receiving adequate care because of a shortage of trained medical interpreters. The hospital employed only four translators, which, according to the task force, was more staff than most private hospitals had but still insufficient. CCH received 9,625 formal requests for translation services in 1991 and 4,397 requests in the first six months of 1992.

CCH responded immediately to the task force's accusation, and director Ruth M. Rothstein promised to allocate funds to employ eight interpreters, said Wendy Siegel, task force chairman and policy specialist for the Chicago Institute on Urban Policy. "We had asked for 10, but this is an important step forward," she said, adding that the hospital's doctors and nurses had stated the need for interpreters.

Siegel advocates both the use of trained medical interpreters and physicians' understanding of patients' cultural needs. Currently in Illinois there is no formal training program for medical interpreters, and many hospitals and physicians rely on bilingual nurses, secretaries, clerks, or even friends and relatives of patients, for translation services.

To address health care access issues, the task force brought together a coalition of refugee and immigrant groups including representatives from several hospitals and medical centers, public health offices, universities and cultural organizations. It recently completed a concept paper on training medical interpreters.

The keys to removing cultural and linguistic barriers include hiring more interpreters and addressing legal issues, Siegel said. "Health institutions have to provide interpreters because of federal law," she said, explaining that often the requirement is met by social service workers who refer patients to hospitals, then accompany them and spend hours waiting to translate.

"There's very little policy in place to address the needs," Siegel noted, citing the weak infrastructure of cross-cultural programs. She also emphasized the importance of providing trained interpretation services to patients, adding that she believes that lack of such services leads to severely compromised care.

The task force's proposed training, outlined in the concept paper, is based on a multilingual model developed at the University of Minnesota, and it incorporates cultural training as well as language, Siegel said. She stressed that the lack of trained services can greatly compromise quality of care in a number of ways, such as patient noncompliance due to lack of understanding.

To create a pool of interpreters, various levels of training and a certification process are designated in the paper. Ideally, individuals would be employed solely "for the express purpose of providing interpreter/translator services to limited-English-proficient patients." In addition to language proficiency, skills should include "cultural sensitivity and mastery of the medical and colloquial terminology ... and the health care interpreter should maintain an unbiased professional demeanor and seek to translate with a high level of accuracy."

"The situation in Chicago is pretty bad," Siegel continued. "We tried to pull together a pool of interpreters [from hospitals], and none of them held the official title of interpreter."

"THE DIVERSITY OF THE PATIENT population is markedly increasing," said Lois M. Nora, MD, assistant dean of clinical curriculum at Rush Medical College in Chicago. Dr. Nora helped institute what she terms "diversity training" for medical students at Rush, a program that was recently featured in *American Medical News*. "The hallmark of diversity training is not only understanding differences, but also helping individuals recognize commonality, that we all have very similar underlying values," she said.

The Rush cross-cultural program features a Spanish language and cultural competence program. "We insist that all students taking the language course have cultural competence," Dr. Nora said. "Sometimes the use of language alone can do more harm than good."

Siegel also noted that even doctors can do more damage with a small amount of language knowledge. Problems can also arise when physicians don't know the language competence of a bilingual staff member. Such untrained personnel are sometimes asked to translate brochures or detailed patient histories.

Diversity training focuses beyond a single language or culture, Dr. Nora explained. The Rush program is still in its early stages, and faculty members are considering what should be included in the program, such as how to work with interpreters. Currently, the program consists of a three-hour orientation for first-year students, in addition to the Spanish course.

CROSS-CULTURAL MEDICINE

Dr. Nora stressed the importance of program expansion and the need for culturally appropriate communication. She cited instances in which the only bilingual translator available was a child related to the patient. "Physicians have to be sensitive as to what level of questions to ask in this situation," she said. When a child is involved, physicians should not ask for a sexual history, for example. This may seem obvious, but Dr. Nora insisted it sometimes happens.

Another Rush faculty member is self-taught in Hispanic culture. Steven K. Rothschild, MD, a family physician and assistant chairman of the department of family medicine, went into medicine to help the medically underserved in inner-city areas. He established a private practice in Pilsen, a largely Hispanic neighborhood on Chicago's Southwest Side, and learned Spanish and the Hispanic culture, including Mexican-American and Puerto Rican community beliefs.

"I got my hands on different materials that included medical issues and specifically social approaches" to cross-cultural medicine, Dr. Rothschild said. He also received help from the Hispanic Health Alliance, which offers its own cross-cultural health care programs. But what helped him the most was talking to people in the community to learn its culture and values, and health care issues.

"The big issue is trust and respect," he said. "Hispanic patients are concerned that you won't understand or that if you do, you won't listen to their explanations."

Dr. Rothschild explained that in Hispanic culture, being respectful means being formal. But at the same time, the physician must convey warmth and caring. Formality includes always using the last name, making eye contact, and using more physical contact. He suggested that physicians sit closer to their Hispanic patients than they normally might.

Celebrating his fifth anniversary in Pilsen in March, Dr. Rothschild said he was surprisingly well accepted from the beginning. He hired an entirely bilingual staff, who helped him better understand both the language and culture of his patients, and who sometimes translate, he said. He even incorporated Spanish art in his office to make patients feel more comfortable.

In working with interpreters, the most important technique Dr.

(Continued on page 14)



JOE HINDLEY

Cultural diversity

(Continued from page 13)

Rothschild uses is making eye contact with the patient. He said interpreters can shade the conversation in either direction by changing certain words the physician uses or vice versa. "A doctor might not hear of a folk remedy that the patient was using" if the interpreter believes it is insignificant information.

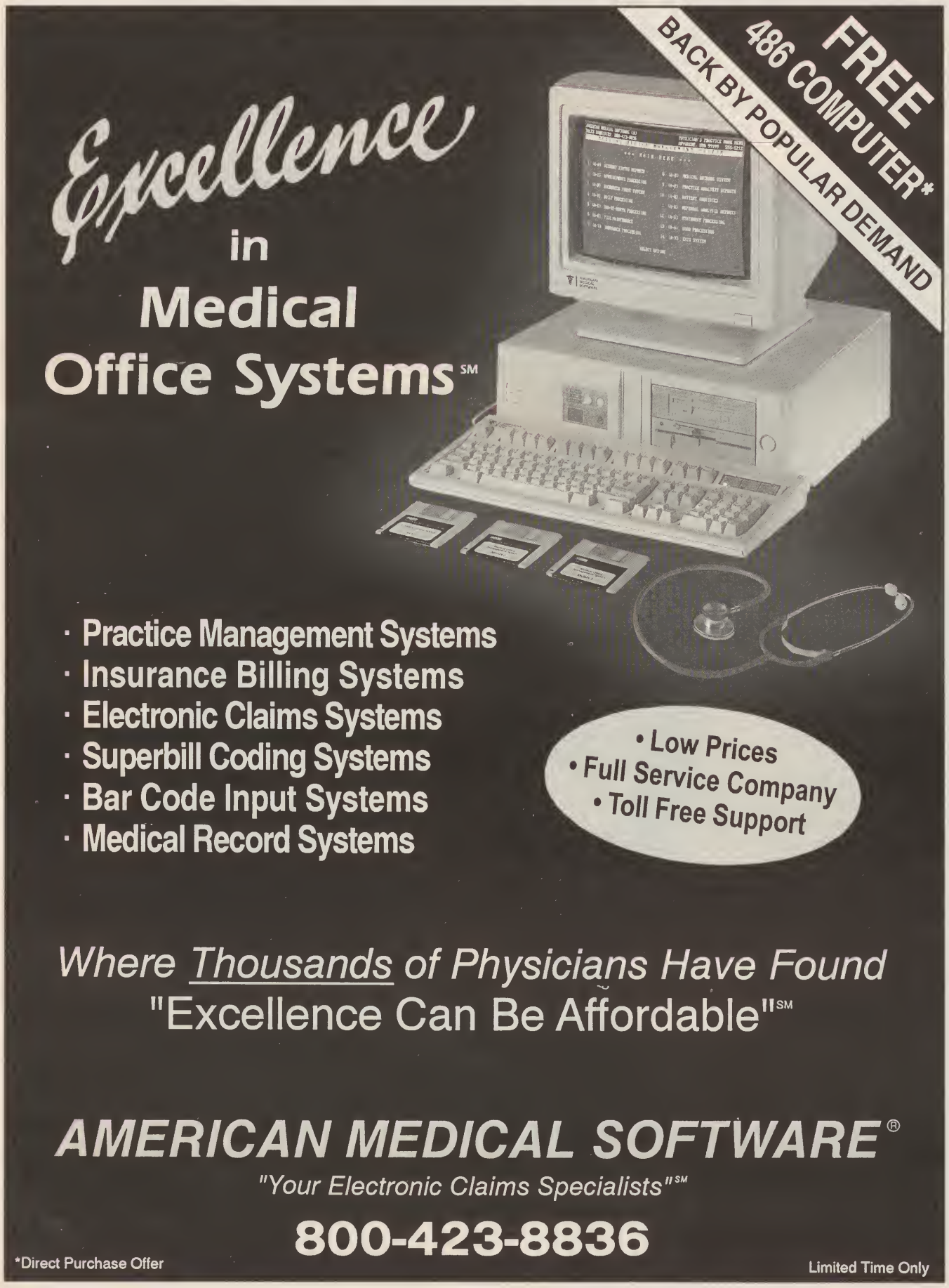
"In hospitals, interpreters are usually volunteers, which can sometimes lead to disasters," he continued, describing a case in which a 17-year-old interpreter called a patient's kidneys his "liver."

"I know enough Spanish to know when they're glossing over the facts," Dr. Rothschild said. Sometimes a patient gives a long answer to a question, and the interpreter will reply with a yes or no. "I judge how long the answer is. If it's too short, I say, 'Why don't you tell me exactly what was said?'"

ALTHOUGH CROSS-CULTURAL TRAINING for both physicians and interpreters, as well as other health care workers, is relatively rare in Illinois, several programs are currently being developed or expanded. The Travelers and Immigrants Aid Health Task Force is in the process of surveying Cook County hospitals and clinics about their use of interpreters. Goals are to offer interpreter training for certification in community colleges, and integrate interpretation into nursing programs and social work curricula.

The American Academy of Family Physicians offers a videotape on racial and cultural biases in medicine, which Dr. Nora recommends as a good starting point for physicians.

"There has been a great deal written against diversity training, because it's thought that it focuses on people's differences, that it's fractionalizing," Dr. Nora said. "But we hope to help people understand that it's not training to be different, but training to communicate." ■



HHA offers cross-cultural programs

As part of its Provider Education Project, the Hispanic Health Alliance in Chicago offers its Spanish Language for Health Care Professionals course, a Spanish language and culture training program. Created to bridge the gap between providers and the community, the course assists physicians in taking medical histories, investigating patient health complaints, conducting physical examinations and giving simple instructions. Most importantly, it helps providers form a personal link with Spanish-speaking patients. HHA offers various levels of this course based on prior knowledge and individual needs.

The organization also presents cultural workshops and a monthly lecture series tackling such topics as women's role in Hispanic culture and AIDS. HHA also provides translation of documents, including newsletters, technical manuals, medical brochures and legal documents.

For more information, health care providers may write to HHA at 1579 N. Milwaukee, Suite 230, Chicago, Ill. 60622; or call (312) 252-6888.

Other cross-cultural resources for physicians include a videotape on racial and cultural biases in medicine by the American Academy of Family Physicians; articles in the *Journal of the American Medical Association* and the *Western Journal of Medicine*, published by the California Medical Association; and medical libraries.

Steven K. Rothschild, MD, assistant chairman of the department of family medicine at Rush Medical College, who practices family medicine in the predominantly Hispanic Pilsen neighborhood of Chicago, has several recommendations for physicians planning to practice in ethnic communities:

- Read medical literature dealing with cross-cultural issues.
- Talk to leaders in the community, such as ministers, school officials and political leaders.
- Create an attractive and positive environment. For example, in a Hispanic community, provide brochures in Spanish, which many organizations, including the Illinois State Medical Society, produce.
- Hire sensitive, bilingual staff.

"Learning a language can be critical," Dr. Rothschild said. "There are major needs across the board, whether they're Spanish, Polish or Vietnamese." ■

– Anna Brown

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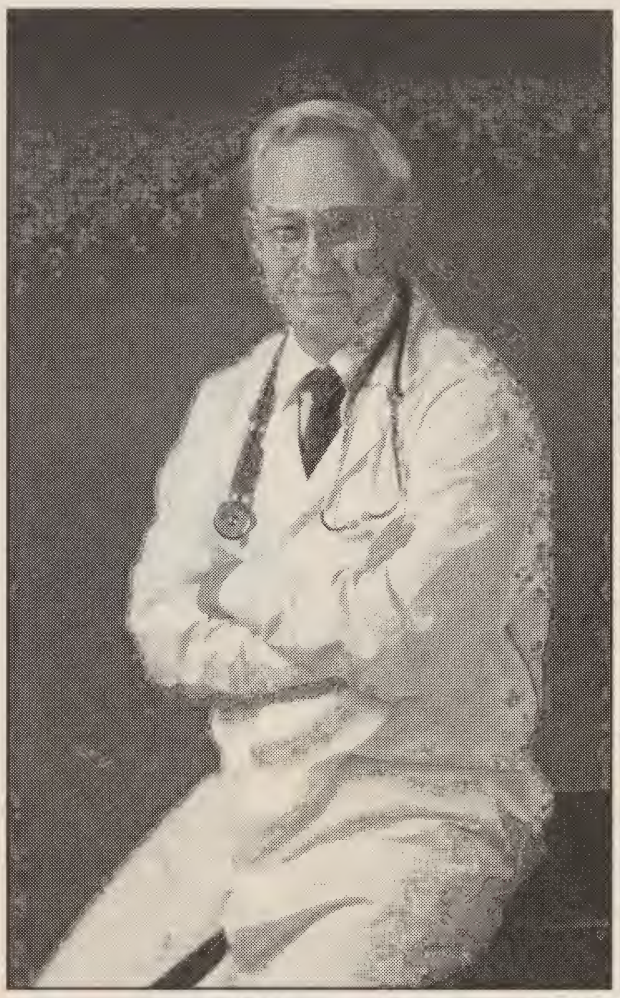
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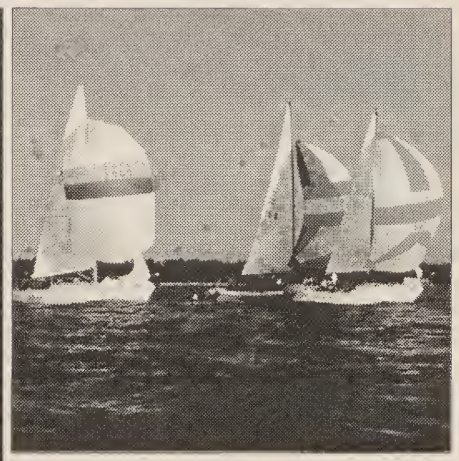
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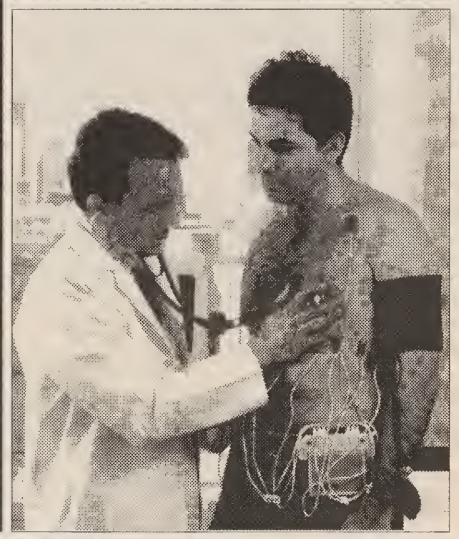
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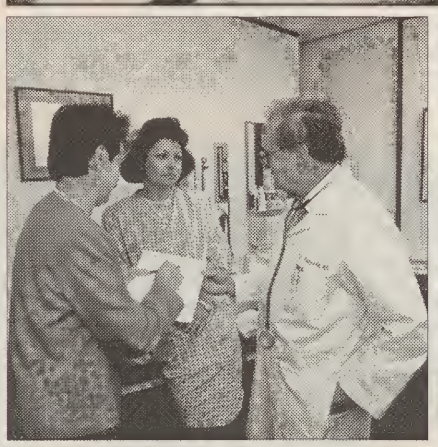
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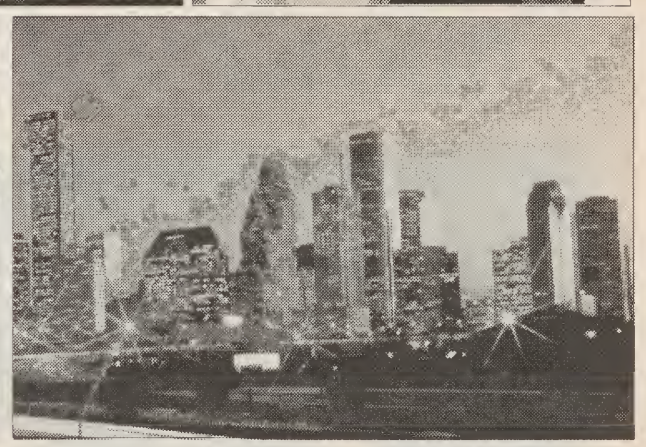
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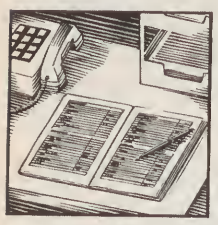
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Tax season update

By James O. Giese, CPA, JD

The Tax Reform Act of 1986 significantly eliminated many tax-saving strategies, but there are still ways to save on taxes and considerations for tax preparation. Of course, you should consult your tax adviser for specific advice.



Filing status – In certain rare circumstances it may be advantageous for a married couple to file separate returns – for example if one person has high medical or miscellaneous expenses. However, the expenses must exceed a certain percentage of the adjusted gross income. By filing separately, more of these expenses are deductible, especially if the spouse who incurred the expenses has a lower adjusted gross income.

Social Security numbers – Your tax return must include Social Security numbers for all your dependents who were at least 1 year old at the end of 1992. There is a $50 penalty for failing to include this information. The IRS has indicated that for 1992 taxes, this penalty will be assessed.

Deductions of self-employment tax and self-employed health insurance – If you owe self-employment tax, one-half of your 1992 liability is deductible. In addition, if you are self-employed and show net profit for the year, or if you received wages from an S corporation in which you are a 2-percent or more shareholder, you can deduct up to 25 percent of your health insurance costs (limited to net profits). The health insurance deduction is not available if you or your spouse was eligible to participate in a health plan offered by an employer. Your employees' health insurance costs are deductible on your business income schedule.

Deduction of qualified mortgage interest – Consumer interest such as interest on an automobile purchase is no longer deductible. However, interest expense is deductible if you borrow money through a home equity loan. If you took out a home equity loan after Oct. 13, 1987, the interest on it is deductible only to the extent such debt does not exceed the lesser of the fair market value of the residence minus your first mortgage, or $100,000. There is no restriction on how you use the loan proceeds. If you took out a mortgage loan after Oct. 13, 1987, to acquire, construct or substantially improve a principal or second residence, you can use the 100-percent mortgage interest deduction only to the extent that the aggregate of such loans does not exceed $1 million.



James O. Giese, CPA, JD, *is a senior manager in the public service group of the tax department at Ernst & Young in Chicago.*

Home refinancing – If you refinanced your home in 1992, the points paid at closing may be partially or even fully deductible. The general rule is that points paid when refinancing an existing mortgage must be written off over the life of the new loan. They are not fully deductible in the year paid because they were not paid in connection with the improvement or purchase of a home, even if your original loan met deductibility requirements. Points for refinancing are fully deductible if paid in connection with home improvement. This is true even if the new mortgage is secured by your main home. To be immediately deductible, points on home improvement loans must be paid from separate funds at closing; they cannot be included in the borrowed amount.

College-student dependents – Generally, the cost of your children's college dormitory space is not deductible. However, if you purchase a condo in which your college-aged dependent child lives while at school, you may be able to generate a deduction because the interest expense for a qualified second residence is deductible. Therefore, if you buy a highly leveraged condo, you may be able to make mortgage payments that approximate what you would otherwise pay in dormitory rent. The interest part of the mortgage and any related property taxes would be deductible. The property's appreciation or depreciation potential and other factors must be considered, though.

Interest expense – Make sure you review your interest expense to ensure it is identified as mortgage, business, investment or personal interest. Remember, personal interest is no longer deductible, but the three other types of interest are usually still deductible.

Interest expense incurred on business-related expenditures is deductible as business interest. So, identify business-related credit card purchases. A similar analysis would apply to investment and mortgage interest. Be sure to keep detailed records so that the IRS can trace the ultimate use of the borrowed dollars that resulted in each dollar of interest expense.

Entertainment expense – Your deduction for business meals and entertainment is subject to a 20-percent reduction. It is critical that you have records allowing you to identify and segregate the meal and entertainment expenses subject to this 20-percent disallowance rule from other transportation and lodging expenses that are fully deductible. ■

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Photo: 1927 Yale Football Team



The services, staff and leadership of the Illinois State Medical Society and the Illinois State Medical Inter-Insurance Exchange are as near as your phone. Use the Society's toll-free number, (800) 782-ISMS, to reach the Society or the Exchange; calls can also be taken on (312) 782-1654. Both the Society and the Exchange phone lines are open from 8:30 a.m. to 4:45 p.m. Monday through Friday; during nonbusiness hours the night line can record brief messages.

In addition, **ISMS President Arvind K. Goyal, MD, is available for membership calls** the first Wednesday of every month, 11 a.m. to noon. Use the toll-free or Chicago number above and ask for extension 1333. ■

Update your address now for license renewal

In the last issue, *Illinois Medicine* reminded you that medical licenses will expire July 31. If you moved since the last renewal period and did not notify the Illinois Department of Professional Regulation of your new address, you may not receive license renewal forms. All address changes must be received by the department before March. They may be submitted in writing only; no changes will be accepted over the phone.

To update your address with the department, clip and complete the adjacent form and mail it to the Illinois Department of Professional Regulation, Licensure Maintenance Unit, 320 W. Washington St., 3rd Floor, Springfield, Ill. 62786. ■

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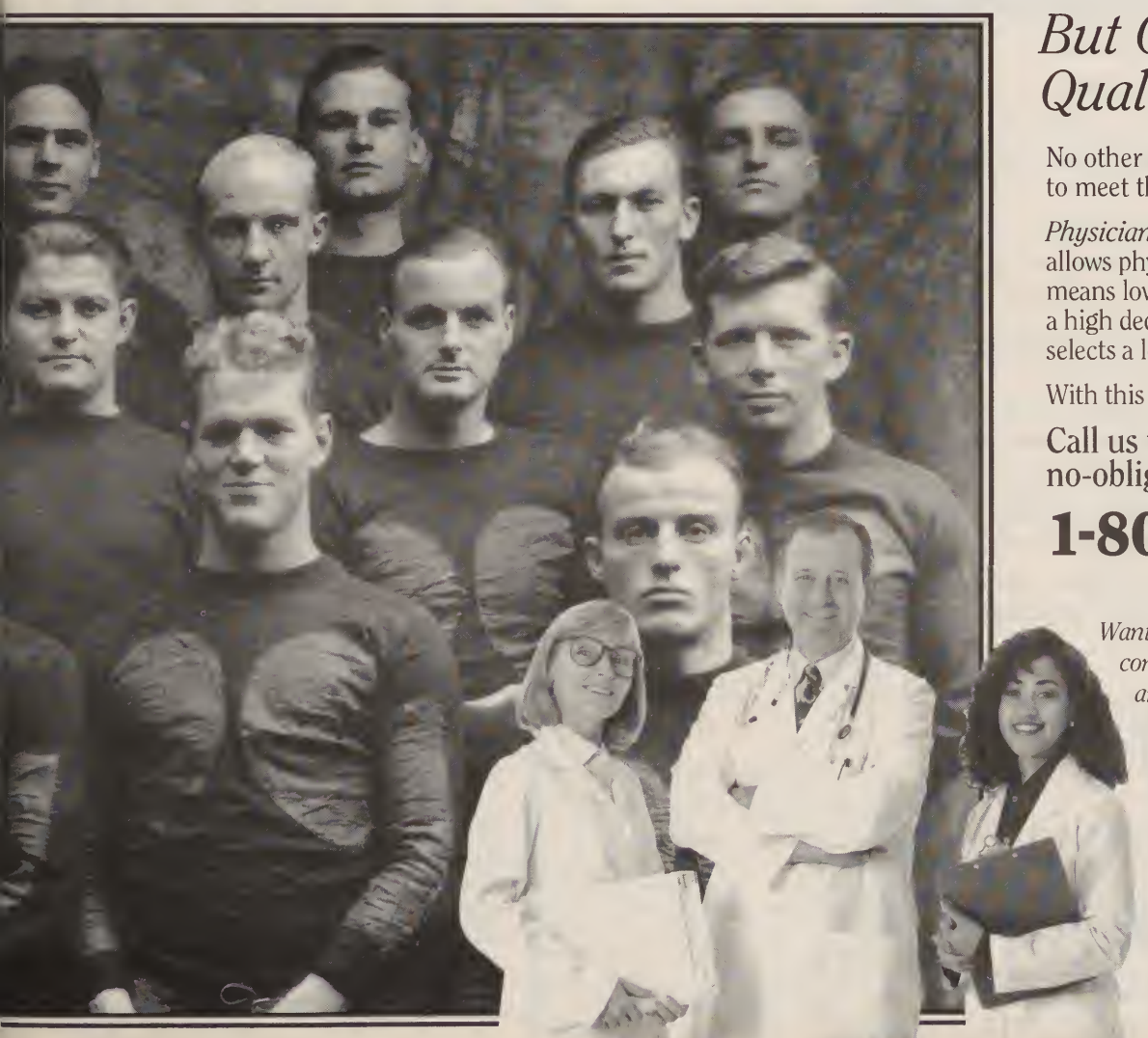
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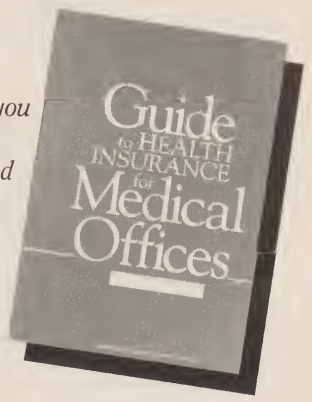
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OBITUARIES

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****Bucy**
Paul C. Bucy, MD, a neurological surgeon from Tryon, N.C. (formerly of Chicago), died Sept. 22, 1992, at the age of 87. Dr. Bucy was a 1927 graduate of the University of Iowa College of Medicine, Iowa City.

****Dickerman**
Henry S. Dickerman Jr., MD, an internist from Springfield, died Sept. 5, 1992, at the age of 84. Dr. Dickerman was a 1935 graduate of Rush Medical College, Chicago.

****Ehrmann**
Evelina W. Ehrmann, MD, an ophthalmologist from LaGrange Park, died Sept. 22, 1992, at the age of 96. Dr. Ehrmann was a 1921 graduate of Rush Medical College, Chicago.

***Halama**
Thomas J. Halama, MD, an obstetrician/gynecologist from Oak Brook, died Sept. 16, 1992, at the age of 60. Dr. Halama was a 1957 graduate of the University of Illinois College of Medicine, Chicago.

***Jakocko**
Peter F. Jakocko, MD, a general practitioner from Chicago, died Sept. 10, 1992, at the age of 72. Dr. Jakocko was a 1944 graduate of Loyola University Stritch School of Medicine, Maywood.

***Juaneza**
Lilith D. Juaneza, MD, an obstetrician/gynecologist from Chicago, died June 15, 1992, at the age of 43. Dr. Juaneza was a 1976 graduate of the College of Medicine of the University of the East, Quezon City, Philippines.

****Jurgens**
Johannes J. Jurgens, MD, a general practitioner from Denver (formerly of Chicago), died July 8, 1992, at the age of 93. Dr. Jurgens was a 1927 graduate of the University of Illinois College of Medicine, Chicago.

***Levy**
Geoffrey L. Levy, MD, a psychiatrist from Arlington Heights, died August 6, 1992, at the age of 67. Dr. Levy was a 1947 graduate of the Faculty of Medicine, University of Liverpool, Liverpool, England.

***Makielski**
Louis J. Makielski, MD, of Paradise Valley, Ariz. (formerly of Flossmoor), died Aug. 5, 1992, at the age of 71. Dr. Makielski was a 1946 graduate of Indiana University School of Medicine, Indianapolis.

Mitchell
Joseph H. Mitchell, MD, of Chicago, died Sept. 3, 1992, at the age of 80. Dr. Mitchell was a 1938 graduate of Howard University College of Medicine, Washington.

***Paul**
John C. Paul, MD, a general practitioner from Woodstock, died Aug. 19, 1992, at the age of 72. Dr. Paul was a 1945 graduate of the University of Pennsylvania School of Medicine, Philadelphia.

****Perritt**
Richard A. Perritt, MD, an ophthalmologist from Chicago, died Sept. 16, 1992, at the age of 89. Dr. Perritt was a 1929 graduate of Loyola University Stritch School of Medicine, Maywood.

***Shorey**
William D. Shorey, MD, a surgeon from Chicago, died June 27, 1992, at the age of 72. Dr. Shorey was a 1945 graduate of Harvard Medical School, Boston.

****Sintzel**
Alois R. Sintzel, MD, of Belleville, died Sept. 11, 1992, at the age of 84. Dr. Sintzel was a 1934 graduate of St. Louis University School of Medicine, St. Louis.

****Smith**
John H. Smith, MD, an obstetrician/gynecologist from Bloomfield, Ind. (formerly of Rockford), died Aug. 11, 1992, at the age of 84. Dr. Smith was a 1939 graduate of Indiana University School of Medicine, Indianapolis.

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Physicians needed in all specialties. Full-time and part-time positions available as well as group or solo practice opportunities in Chicago/Illinois and multistate areas. Contact: Debbie Aber, Physician Services, 1146 Parker Lane, Buffalo Grove, IL 60089; (708) 541-9332, fax (708) 541-9336.

Oshkosh, Wis. – Medical groups are recruiting in emergency medicine, internal medicine, Ob/Gyn, rheumatology and child neurology. Mercy Medical Center has an active medical staff of 120 physicians in all medical specialties. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley (metro area of 350,000 people). University of 12,000 students. Competitive financial packages. Contact Christopher Kashnig, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902. Call (414) 236-2430; fax (414) 231-5677.

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Wisconsin – Michigan. What are your prerequisites for a practice? Strelcheck & Associates, an extension of our clients' recruiting departments, has several opportunities that might be of interest to you. We currently represent our clients in the areas of dermatology, emergency medicine, neurosurgery, occupational medicine, oncology, orthopedics, orthopedics-hand, otolaryngology, psychiatry and urology. Locations in metropolitan areas, mid-size cities, on lakes, streams or near forests – you choose. To discuss your practice preferences and these opportunities, please call our toll-free number, (800) 243-4353 or send your CV to Strelcheck & Associates, Inc., 10624 N. Port Washington Road, Mequon, WI 53092.

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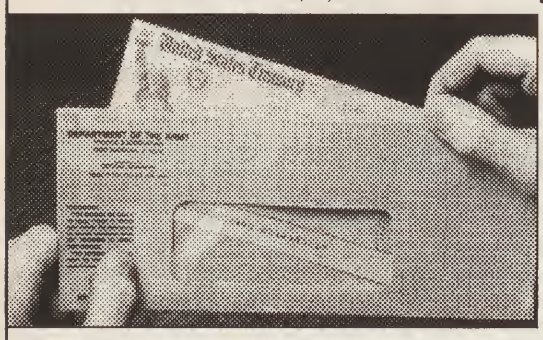
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Legislator

(Continued from page 1)

Branch meeting Jan. 20 at Holy Cross Hospital on Chicago's Southwest Side.

Jere E. Freidheim, MD, chairman of the Illinois State Medical Society Board of Trustees and the Illinois State Medical Inter-Insurance Exchange Risk Management Committee, called Topinka a "trusted friend of medicine" after he provided an overview of the Exchange risk management program.

"For the first time in at least 10 years, we have a position of barter, negotiation and leverage [in the Senate] so that maybe we can accomplish something in tort reform," Topinka said. "Anything that we can pass to a Republican governor will be signed by a Republican governor," she assured physicians. She also asked for their support in re-electing a Republican governor in 1994.

Topinka, who has been a state senator since 1985, spoke out strongly against the current U.S. tort system and the prominence of plaintiffs' attorneys in American society. "The United States is three times higher in torts than [is] any other country in the world," she said, adding that the United States could not be reasonably compared to other countries in discussions of universal health insurance because of its faulty tort system.

"Trial law is considered a growth industry," Topinka continued. Plaintiffs' attorneys earn more than $10 billion a year, and the country is currently gaining 30,000 new lawyers per year, she noted.

"Where there are more lawyers, there is more law," she said, attributing the popularity of the profession to television and the media, which make law seem inviting.

Addressing the issue of litigation cost, Topinka said the Republican Senate will be able to take action in the next year. "We are in the drafting stage of a bill that will put a cap of $250,000 on pain and suffering damages in malpractice cases. We are hoping to prevent juries from loading up damages because they feel sorry for a severely injured patient."

The result of such a bill, she said, would be to allow juries time to assess an amount based on the facts of the case rather than emotion. In addition, it would give appellate courts greater latitude to reduce awards that are unsupported by evidence.

"The chances of passing this bill, especially in the Senate, are very, very good," Topinka said.

A bill that has already been filed, S.B. 3, is the Product Liability Improvement Act. The bill limits punitive damages in product liability suits and creates a presumption that a defendant is not liable when a product is in accordance with state or federal law or regulation.

Product liability directly affects your profession and hits at the heart of medical research, Topinka told the physicians.

Another Senate bill certain to affect the medical profession would discourage frivolous suits by requiring the loser to pay the prevailing party's court and attorney fees.

In her most assertive bid of the evening, Topinka urged physicians to become involved in the legislative process by learning the names of their legislators and contacting them about important issues. "The only way to instigate change is legislatively," she said. ■



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Edgar's address

(Continued from page 1)

the new Illinois Department of Public Aid managed care initiative, Healthy Moms/Healthy Kids. The program's goal is "preventing major health problems by helping poverty-stricken mothers and children to establish regular relationships with physicians," he said.

Edgar said his administration remains committed to providing superior care for Illinoisans who have mental illness or disabilities. "We are determined to make sure our state hospitals are adequately staffed and provide high-quality care. But we are equally committed to developing a comprehensive system of community-based programs that will allow those who need not be treated in state facilities to lead productive and dignified lives in their own communities."

The success in "aggressively capturing federal dollars" for the Medicaid program through the health facilities assessment plan also drew kudos from Edgar. "By working with the federal government, we have developed a program that has brought $740 million additional Medicaid dollars to Illinois," he noted. "We have rescued financially strapped hospitals and nursing homes that treat the poor, and we have expedited payment to Medicaid providers who still have to wait too long [for reimbursement]. And if we do not continue that program or find a realistic alternative, we will see health care for the poor suffer dramatically."

Although the tenor of his address was positive, Edgar tempered his remarks by cautioning lawmakers that there will still be "tough fiscal decisions" to be made during this year's budget machinations. "To be sure, funding health care for the poor will be one of the major challenges you and I face this year." ■

Task force report

(Continued from page 1)

spiraling health care costs and improve access. The task force's first responsibility was to advise Edgar about continuing the assessment plan for fiscal 1994.

The group – made up of representatives from the health care profession, insurance industry, business and government – formulated its recommendations based on the fiscal constraints of the state budget and political reality. While most task force members agreed there may be better ways to fund health care for the poor, they said they recognized that other funding sources are currently untenable. Among the options the task force considered were dedicating the state's revenue growth to Medicaid, increasing the state income tax or "sin taxes" on tobacco and alcohol, downsizing state government, instituting a service tax and reinstating the tax on food and drugs.

> *Modifications include an exemption for rural hospitals, whenever permitted.*

Because no workable alternatives could be identified that would make up the $1.5 billion budget gap if the assessment program were scrapped, the task force recommended a two-year temporary continuation of provider assessments, with some modifications. This recommendation is intended to replace the language in current state law scheduled to sunset June 30, when the state's 1993 fiscal year ends. Illinois physicians are not included in the assessment program.

The program modifications outlined by the task force include an exemption for rural hospitals, whenever permitted under federal law. This exclusion is desirable because many rural hospitals have high numbers of Medicare patients. That makes it more difficult for these institutions to shift the cost of the assessments to their patients because the federal government controls Medicare payment rates. "This poses a very severe burden for these rural hospitals," said Illinois Department of Public Aid Director Phil Bradley.

By pumping more dollars into the Medicaid program through assessments, the state has been able to substantially increase institutional provider reimbursement rates. Without the assessment monies, hospitals and nursing homes would face dramatic rate cuts. "It would be difficult to imagine the long-term care industry with rates reduced so sharply they would affect quality [of care]," said task force chairman Ernie Wish. "We think that's inadvisable."

Although some legislators, including House Minority Leader Lee A. Daniels (R-Elmhurst), oppose continuing what they call a "granny tax," Wish said he hopes legislators will keep "an open mind" about continuing assessments. The task force recommends that the governor, legislators and long-term care representatives collaborate and examine alternatives to the current $6.30-a-day tax nursing homes pay in assessments, Wish said. "But we would need a 10-percent flat tax" on nursing homes to generate the same revenue as the current $6.30 per-day assessment, he explained. If viable alternatives cannot be found, the current assessment must continue, the task force said.

In addition, Bradley said the cash flow created by the assessment program allowed the state to take out loans to speed up the payment cycle. All health care providers benefited from these loans by receiving quicker reimbursement.

The task force also recommended that Illinois implement "reasonable cost containment measures" for Medicaid.

Now that the task force members have completed the first phase of their work, they will turn their energies to the longer-range goals of health care reform. Five subcommittees addressing financing, managed care, access, malpractice reform and long-term care will begin meeting shortly and will report their progress to the full group April 1. ■

Booklets

(Continued from page 1)

"These booklets can play a vital role in encouraging seniors to become partners with their doctors, for better health."

The booklet allows patients to record doctors' visits, prescribed and over-the-counter medications, drug reactions, doctors' instructions and patient questions. Although the booklets were designed specifically for the "Partners for Health" program and seniors, patients of all ages can benefit from its contents, Dr. Goyal added.

ISMS members interested in joining the "Partners for Health" speakers bureau or obtaining copies of the Personal Health Records may write to the ISMS public relations department, Twenty North Michigan Avenue, Suite 700, Chicago, Ill. 60602; or call (312) 782-1654 or (800) 782-ISMS. ■

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Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General.**)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

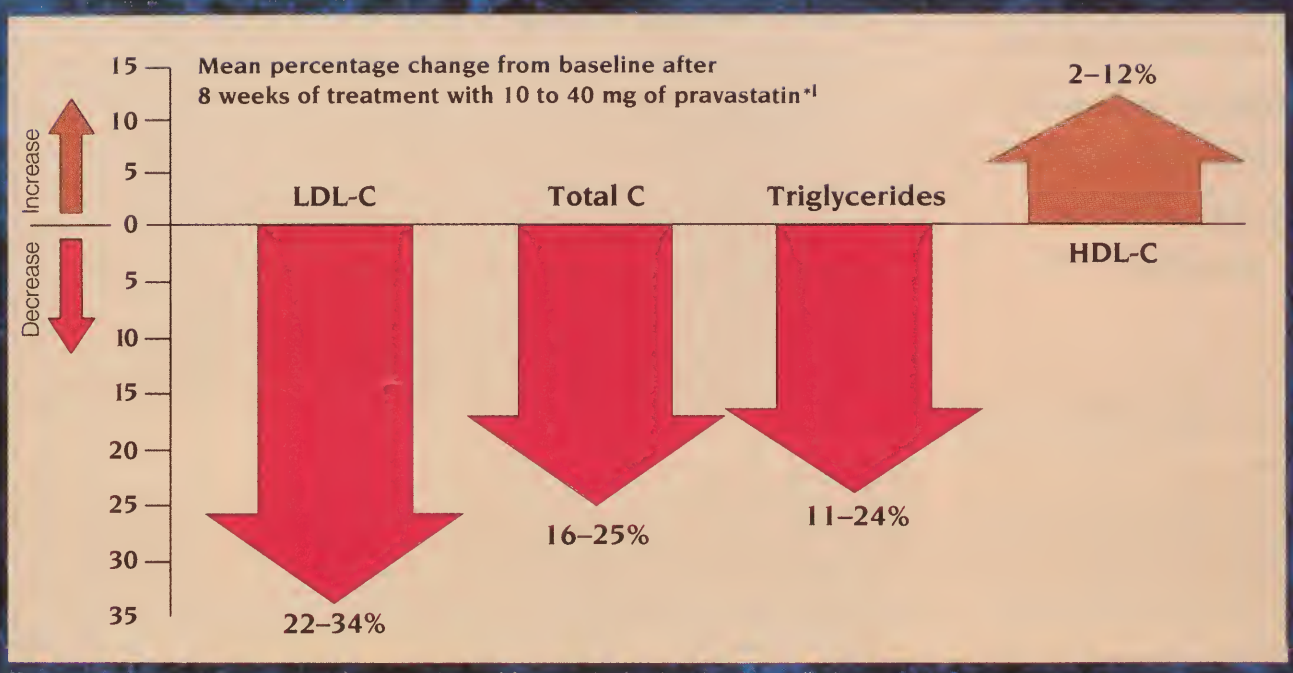
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Effective cholesterol control

Consistently and significantly reduces total C and atherogenic LDL-C; positively affects other key lipids



*Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

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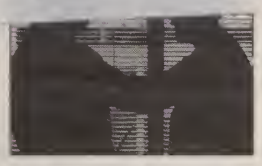
pravastatin sodium 20 mg tablets

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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...IANS TO PRODUCTS LIABILITY (PAGE 9)



Medical schools teach the personal touch

PAGE 12

Illinois Medicine

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GOVERNORS ADOPT HEALTH CARE POLICY

PAGE 8

HCFA halts lab's cytology operation

CLIA ACTION: A Bloomington reference lab ceased all cytology testing following a government inspection. By Tamara Strom

[BLOOMINGTON] The Illinois Department of Public Health is alerting physicians who sent specimens for cytology testing to Stroink Pathology Laboratories Inc., in Bloomington about potentially inaccurate test results issued during the past two years. IDPH acted in its capacity as a contractor for the federal government under the Clinical Laboratory Improvement Amendments of 1988 program.



In the first major action of its kind under the new CLIA regulations, Stroink labs was ordered to stop all cytology testing effective Jan. 30 or face sanctions.

A federal investigation was undertaken in response to formal complaints lodged by current and former employees about the volume of cytology tests performed by the reference lab and the accuracy of the

(Continued on page 22)

INSIDE

Illinois ranks sixth in total AIDS cases

PAGE 4

Illinois peds react to vaccine program

PAGE 5

Point-Counterpoint highlights pharmaceutical costs

PAGE 7

DEPARTMENTS

News Briefs....2, 3

Commentary.....6

ISMIE Update 9

Obituaries 15

IDPR Disciplines 16

Members in the News.....18

Classifieds 19

Jailing called 'intimidation'

Vest contempt ruling overturned

RULE 224: An appellate court dismissed contempt charges against a physician whose improper jailing outraged the medical community. By Anna Brown

[MT. VERNON] Illinois physicians are safe, for now. Barring further appeal, a Belleville physician and his two attorneys were acquitted of contempt charges Feb. 11 in a highly publicized case centering on the interpretation of an Illinois Supreme Court rule setting discovery limits for plaintiffs in depositions. The decision has far-reaching implications for Illinois tort law, since a verdict for the plaintiff could have opened the doors for individuals, including doctors, to be interrogated without having been sued.



BELLEVILLE NEWS-DEMOCRAT

James V. Vest, MD

On April 2, 1992, James V. Vest, MD, defense attorney Charlene A. Cremeens and Dr. Vest's personal attorney Gerald L. Montroy were jailed by James M. Radcliffe, judge of the Circuit Court of St. Clair County, because Dr. Vest refused to answer a question during a deposition. No lawsuit had been filed against Dr. Vest, who had been subpoenaed

(Continued on page 17)

Smoking suit ends in tobacco victory

LABEL VERDICT: Jurors determine cigarette labels were enough warning for an ailing ex-smoker. By Anna Brown

[BELLEVILLE] On the evening of Jan. 29, jurors in the St. Clair County case against the country's second largest tobacco company handed down their verdict: R.J. Reynolds Tobacco Co., the Tobacco Institute and Reese Drug Stores did not conspire to hide information from the plaintiff about the dangers of smoking.

Charles Kueper, 51, a retired Army veteran who was diagnosed with lung cancer in 1990, had sought $3 million in damages from the defendants. The suit was the first to be filed against the tobacco industry since the U.S. Supreme Court ruled that warning labels would not automatically shield cigarette manufacturers from damages. However, jurors in the highly publicized Belleville case disagreed with that ruling by determining that Kueper was

(Continued on page 23)

ISMS IN THE COMMUNITY

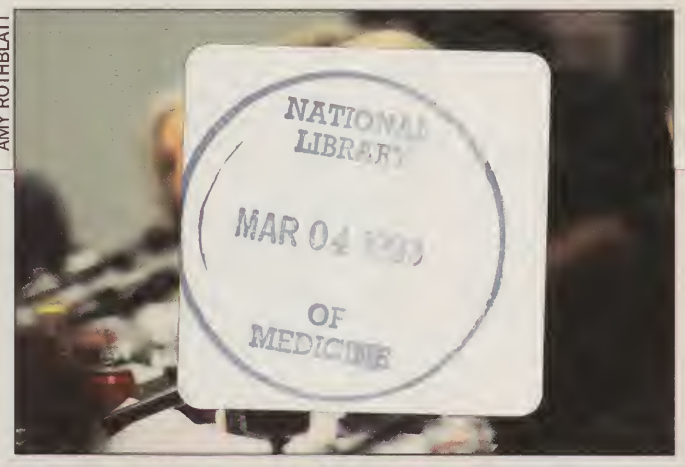
PHYSICIAN SPEAKERS TO ADDRESS RURAL HEALTH CRISIS

As Illinois' rural communities search for ways to establish or retain comprehensive health care programs, the Illinois State Medical Society is finding ways to help. The newest rural health program developed by the Society will bring rural doctors face-to-face with community groups. The new rural health speakers bureau is available to communities seeking information about developing responses to common rural health problems.

The speakers are physician members in active practice in rural communities throughout Illinois. With the help of the county medical societies, physicians will speak at town meetings or to smaller community groups interested in preventing or resolving health care problems in their community. Speakers will not offer solutions, but will present ideas, stressing the importance of working together and planning within the community.

"It's a grass-roots approach," said George

(Continued on page 23)



AMY ROTHBLATT

CAROLYN W. BRENT, MD, associate professor of anesthesia at Northwestern Memorial Hospital, joined 37 other physicians, health care administrators and academicians at a Feb. 2 roundtable in Chicago about the progress of women in research and academic medicine.

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Breast cancer more severe in young women

CONFERENCE: Cancer experts say breast cancer is a different and more aggressive disease in young women. By Gina Kimmey

[BETHESDA, MD.] The message from the National Cancer Institute to young women with breast cancer is not good. At a recent two-day conference, cancer experts revealed what they do and don't know about breast cancer in pre-menopausal women. They know the disease takes its greatest toll on younger women, but they don't know why.

About 25 percent of breast cancer occurs in pre-menopausal women. NCI's Surveillance, Epidemiology, and End Results program reported on survival patterns in women under age 40 with the disease. The results showed that the probability of death due to breast cancer within five years after diagnosis among women in the 20-29 age group was 26.4 percent for white women and 33.7 percent for black women. For the 30-39 age group this probability was 20.1 percent for white women and 32.4 percent among black women. The disease seems to be more difficult to treat in younger women. The tumors found in young women lack estrogen receptors, so estrogen-based treatments like tamoxifen – a popular chemotherapy for breast cancer – don't work.

OF WOMEN UNDER AGE 40, about 11,700 are diagnosed with breast cancer yearly. Joseph Marcus, MD, an assistant professor of pathology at the Creighton University School of Medicine in Omaha, Neb., said that more than half of the breast cancers he studied in women under 30 were hereditary, and they grew faster and recurred more often than those in older women. Except for family history the usual risk factors don't apply. Instead, cases indicate that younger women can be at risk if they started taking oral contraceptives before age 20, took birth-control pills for 10 or more years, had a surgical abortion at an early age, or began menses before age 12.

For now, young women are advised to perform self-exams regularly to check for lumps. Ellen B. Mendelson, MD, chief of mammography at the University of Pittsburgh School of Medicine, said mammography for women in their teens and 20s is controversial. Because it is a low-yield procedure for even those at high risk, most women of that age won't seek a mammogram until they have found a lump, and by then a mammogram does them the least good.

The discussion ended with experts agreeing that more clinical trials need to be designed to determine whether young women respond differently to treatment than do older women. They suggested that characteristics such as hormonal status and metabolism that vary during the life span may well influence treatment. ■

Anesthesiologist wins $9.2 million judgment

[NEW YORK] Jan Robert Purgess, MD, a New York anesthesiologist, was awarded $9.2 million by a federal jury to compensate him for a hospital's "improper termination of his clinical privileges," the American Medical Association reported in its *Medical Staff Legal Advisor.*

After working as a member of the hospital's provisional medical staff for 10 weeks, the facility revoked his privileges for alleged quality issues, the AMA said. The hospital contended it did not owe Dr. Purgess due process because he was only a provisional staff member.

But in a lawsuit against the hospital, Dr. Purgess said he was given exceptionally difficult cases as a way of strong-arming him out of the hospital. The anesthesiologist also sued the hospital for defamation of character, antitrust violations, "tortious interference with prospective advantage" and breach of contract, the AMA reported.

The jury sided with Dr. Purgess. It awarded him $3.5 million for defamation of character, $700,000 for tortious interference with prospective advantage, $400,000 for breach of contract and $4.6 million in punitive damages, according to the AMA. The hospital is petitioning the court to reverse the verdict or reduce the award.

In the meantime, the hospital medical staff has amended its bylaws to provide for due process hearings for provisional staff members. ■

Media renews spotlight on downstate cancers

[TAYLORVILLE] After one of the four Taylorville children who have a rare form of childhood cancer died in January, downstate newspapers again picked up on the story. But officials are still no closer to determining the cause of this unusual cluster of neuroblastoma cases after more than two years of study, according to the Illinois Department of Public Health.

A new study of the children and their families, conducted jointly by IDPH and Southern Illinois University, is currently under way, said Tom Shafer, IDPH spokesperson. The genetic examination could reveal whether the four cases share a common cause. The study results will be released as soon as the DNA testing is completed. Earlier investigations of the children and their family members did not yield a definitive cause.

There is no known cause for neuroblastoma, a cancer that strikes only about 500 children nationwide annually. Taylorville's four reported cases in just a few years make the town a statistical anomaly, but researchers do admit that random clusters of cancers sometimes inexplicably occur.

However, some Taylorville residents, including the parents of the affected children, attribute the cancer to an abandoned utility plant where coal tar was stored in underground tanks. An environmental cleanup of the site was performed in 1987, before any of the Taylorville children with neuroblastoma were conceived, Shafer said, adding that no environmental link to the cancers has been established. ■

Medical supply fraud draws stiff sentences

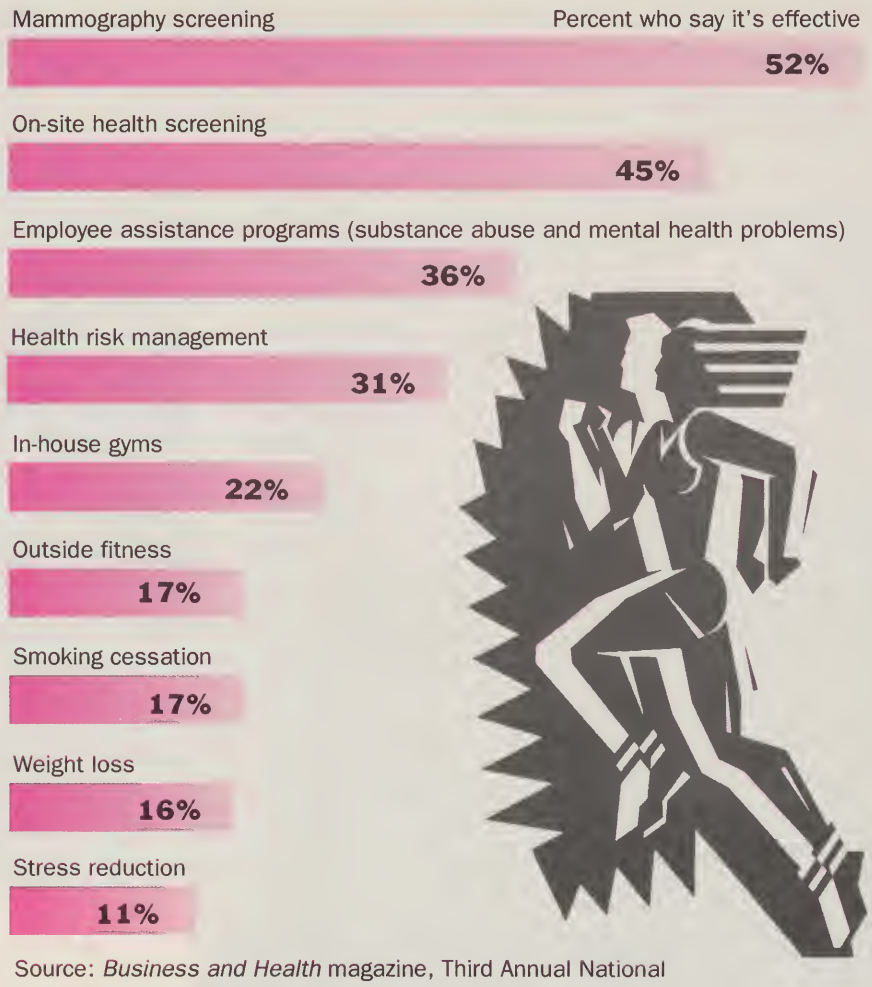
[COLUMBUS, OHIO] A Dublin, Ohio, woman and her medical supply firm were ordered to pay more than $200,000 in restitution for defrauding the Medicare system. The U.S. district judge presiding in the case also sentenced the woman to a two-year suspended jail term, with three months served and five years of probation.

The woman, Ann Boggs, pleaded guilty to one count of mail fraud for the Medicare billing scheme she conducted between 1986 and 1988, according to Barbara L. Beran, U.S. attorney for the Southern District of Ohio. Through her medical supply company, Boggs sold urological catheterization units to Ohio nursing homes to be used as low-cost feeding tubes for patients. Boggs then billed Medicare for more than 31,000 of these catheterization units, altering patient diagnoses to support the need for urological catheters. Claims for 1,600 of the units were submitted for one patient alone, Beran said. When used as dietary devices, the catheters are not reimbursable under Medicare, the attorney added.

The Ohio case is part of the federal government's ongoing initiative to combat Medicare and other health insurance fraud, Beran said. Fraud "victimizes not only the U.S. taxpayer, but also patients, health care providers and the dedicated, honest health care professionals who make up the vast majority in the health care industry," she said in a Feb. 3 press release announcing the sentencing. ■

PHYSICIAN FACTS

Wellness programs employers consider best



Source: *Business and Health* magazine, Third Annual National Executive Poll, 1992

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Columbus Hospital to expand

[CHICAGO] Following the recent trend of Chicago hospital expansions, Columbus-Cabrini Medical Center announced Jan. 13 a plan to create office space worth $15 million for physicians and staff. The new office building on Chicago's North Side will comprise 62,500 square feet of physician office space and 312 parking spaces for physicians, staff and patients.

"The Near North Side of Chicago is home to some of the finest medical facilities and professionals in the country," said Chief Executive Officer Lee Dominaco, announcing the proposal. "Like other institutions located within that prestigious 'health corridor,' we face the challenges of retaining an excellent team of physicians and managing costs of providing health care to patients. Space is an important piece of this equation – doctors need adequate office space designed to provide efficient outpatient care."

In addition to his position at Columbus-Cabrini, Dominaco is currently serving as a member of Gov. Jim Edgar's Health Care Reform Task Force.

The project is scheduled to begin in mid-1993 and to be completed by December 1994. Columbus' expansion plan comes several months after Northwestern Memorial Hospital announced its plans to build a new hospital facility costing $600 million. ■

Cook County offers Norplant

[CHICAGO] Following the 1992 reinstatement of a limited number of abortions at Cook County Hospital, officials moved again last month to increase family planning options the hospital offers. The hospital began offering Norplant the last week of January as part of the hospital's birth control services, Cook County Board President Richard J. Phelan announced. More than 15,000 patients annually receive family planning services from the hospital and its clinics. ■

M. CANDEE STUDIOS



JAMES H. ANDERSEN, MD, 1990 president of the Illinois State Medical Society, addressed the eighth annual meeting of the ISMS Hospital Medical Staff Section Feb. 6 in Chicago. He spoke on the proposed revisions to the standards of the Joint Commission on Accreditation of Healthcare Organizations as they affect medical staffs.

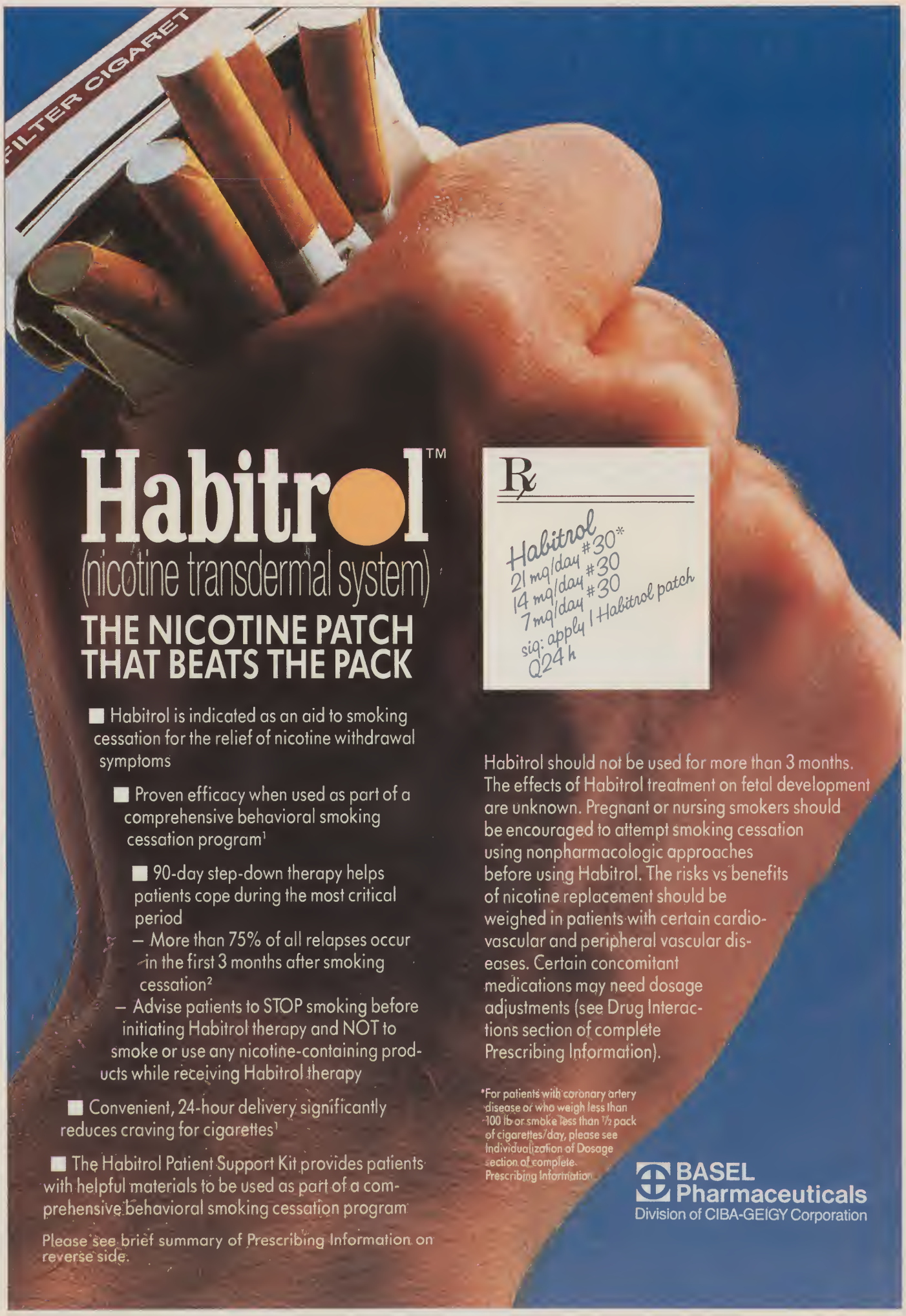
Taxpayers may contribute to Alzheimer's research

[SPRINGFIELD] A lack of contributions has left only one health-related checkoff box on Illinois tax returns. State taxpayers wishing to contribute to the Alzheimer's Disease Research Fund may do so by marking line 15c on Illinois 1040 tax forms.

"We ask that taxpayers once again consider this worthy cause as they prepare their state income tax returns," said John R. Lumpkin, MD, director of the Illinois Department of Public Health. IDPH administers the Alzheimer's fund. "Each contribution to this fund will assist Illinois scientists in their search for more effective ways to diagnose and treat this debilitating disease, which afflicts about 200,000 persons in our state."

The Alzheimer's fund has received more than $1 million in donations in the seven years it has been on state tax forms. During that time, the money has been allocated to 50 researchers by the state's Alzheimer's Disease Act Advisory Committee, Dr. Lumpkin said.

To remain on tax forms from year to year, funds must collect a minimum of $100,000 by Oct. 1. The tax-deductible donations can be made in dollar amounts only, with donations either deducted from taxpayers' refunds or added to the amount owed. Previously, taxpayers have had other options for donating to health-care-related funds such as the Ryan White AIDS Research Fund. But only the Alzheimer's fund reached the $100,000 minimum collection for the 1991 tax year, making it the only fund included on 1992 income tax forms. The Alzheimer's research fund has reached the $100,000 mark since it was first placed on the tax forms in 1986, IDPH said. ■



Illinois ranks sixth in total AIDS cases

1992 STATISTICS: IDPH released year-end AIDS figures Feb. 8. By Tamara Strom

[SPRINGFIELD] Illinois' new AIDS cases jumped 17 percent in 1992, bringing the state's total reported cases to 8,202, the 6th highest in the nation, according to the Illinois Department of Public Health. The 1992 figures show 1,899 AIDS cases were reported last year, compared with 1,621 in 1991.

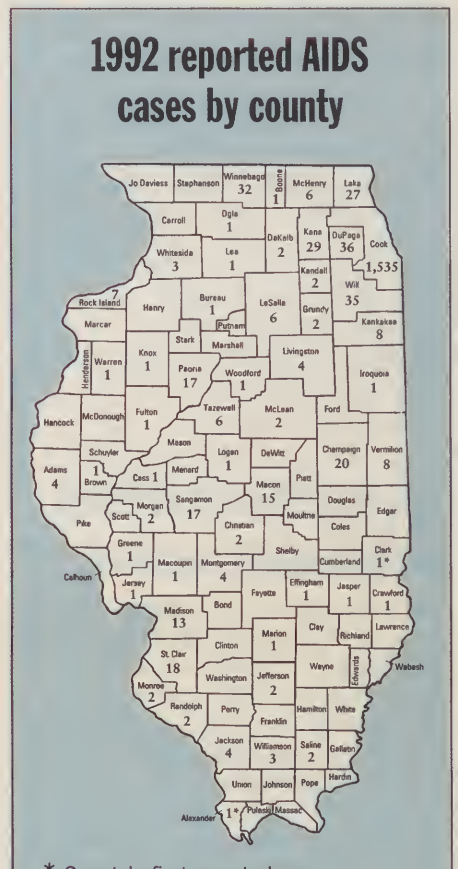
The most noticeable increases were among IV drug users, women, heterosexuals and minorities, said IDPH Director John R. Lumpkin, MD. "We must adapt to meet the challenges of the disease's latest phase," Dr. Lumpkin said. "Of course, we cannot forget the AIDS threat to the homosexual/bisexual community, but we must recognize this deadly disease is now stalking minorities, women and those who share needles to inject drugs."

Overall, the number of cases among homosexual and bisexual males still ranks the highest, but the 1,083 cases reported in 1992 represent only a 9-percent increase from 1991, he said. AIDS is increasing most rapidly among IV drug users; the 483 reported cases in 1992 represent a 71-percent jump over the 282 cases reported last year, according to IDPH statistics.

Dr. Lumpkin said Clark and Alexander counties reported AIDS cases for the first time in 1992; now 90 Illinois counties have reported residents with AIDS. Throughout the rest of the downstate area, AIDS cases increased 8 percent in 1992. Chicago cases rose 23 percent, and in the metropolitan Chicago area, which includes the city, AIDS increased 18 percent.

Despite these jumps in reported cases in 1992, IDPH saw a 72-percent drop in AIDS cases among individuals who received blood transfusions and a 14-percent drop among hemophiliacs. This drop in AIDS cases from old blood transfusions is expected to continue in light of the now-safe blood supply.

Dr. Lumpkin predicted that Illinois will see large-scale increases – in the neighborhood of 75 percent – of reported AIDS cases in 1993 because of the expanded definition of the disease accepted by the U.S. Centers for Disease Control and Prevention starting Jan. 1. The definition now includes patients who have pulmonary tuberculosis, invasive cervical cancer or recurrent pneumonia.



* County's first reported case
Source: Illinois Department of Public Health

The CDC also lowered to 200 the CD-4 cell count of HIV-positive patients considered to have AIDS. This expanded definition could significantly increase the number of reported cases among women and IV drug users, IDPH said.

IDPH runs 51 HIV counseling and testing centers throughout Illinois, Dr. Lumpkin said. Last year, these centers served 54,000 people, 46 percent more than in 1991. ■

IDPR seeks medical coordinator

Physicians interested in the Illinois Department of Professional Regulation full-time position of chief medical coordinator should send inquiries or applications to the director, Illinois Department of Professional Regulation, 100 W. Randolph, Suite 9-300, Chicago, Ill. 60601; or call (312) 814-4934. ■

Habitrol™
(nicotine transdermal system)
Systemic delivery of 21, 14, or 7 mg/day over 24 hours

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
Habitrol treatment is indicated as an aid to smoking cessation for the relief of nicotine withdrawal symptoms. Habitrol treatment should be used as a part of a comprehensive behavioral smoking cessation program.

The use of Habitrol systems for longer than 3 months has not been studied.

CONTRAINDICATIONS
Use of Habitrol systems is contraindicated in patients with hypersensitivity or allergy to nicotine or to any of the components of the therapeutic system.

WARNINGS
Nicotine from any source can be toxic and addictive. Smoking causes lung cancer, heart disease, emphysema, and may adversely affect the fetus and the pregnant woman. For any smoker, with or without concomitant disease or pregnancy, the risk of nicotine replacement in a smoking cessation program should be weighed against the hazard of continued smoking while using Habitrol systems, and the likelihood of achieving cessation of smoking without nicotine replacement.

Pregnancy Warning
Tobacco smoke, which has been shown to be harmful to the fetus, contains nicotine, hydrogen cyanide, and carbon monoxide. Nicotine has been shown in animal studies to cause fetal harm. It is therefore presumed that Habitrol treatment can cause fetal harm when administered to a pregnant woman. The effect of nicotine delivery by Habitrol systems has not been examined in pregnancy (see PRECAUTIONS, Other Effects). Therefore pregnant smokers should be encouraged to attempt cessation using educational and behavioral interventions before using pharmacological approaches. If Habitrol therapy is used during pregnancy, or if the patient becomes pregnant while using Habitrol treatment, the patient should be apprised of the potential hazard to the fetus.

Safety Note Concerning Children
The amounts of nicotine that are tolerated by adult smokers can produce symptoms of poisoning and could prove fatal if Habitrol systems are applied or ingested by children or pets. Used 21 mg/day systems contain about 60% (32 mg) of their initial drug content. Therefore, patients should be cautioned to keep both used and unused Habitrol systems out of the reach of children and pets.

PRECAUTIONS
General
The patient should be urged to stop smoking completely when initiating Habitrol therapy (see DOSAGE AND ADMINISTRATION). Patients should be informed that if they continue to smoke while using Habitrol systems, they may experience adverse effects due to peak nicotine levels higher than those experienced from smoking alone. If there is a clinically significant increase in cardiovascular or other effects attributable to nicotine, the Habitrol dose should be reduced or Habitrol treatment discontinued (see WARNINGS). Physicians should anticipate that concomitant medications may need dosage adjustment (see Drug Interactions).

The use of Habitrol systems beyond 3 months by patients who stop smoking should be discouraged because the chronic consumption of nicotine by any route can be harmful and addicting.

Allergic Reactions: In a 6-week open-label dermal irritation and sensitization study of Habitrol systems, 22 of 220 patients exhibited definite erythema at 24 hours after application. Upon rechallenge, 3 patients exhibited mild-to-moderate contact allergy. Patients with contact sensitization should be cautioned that a serious reaction could occur from exposure to other nicotine-containing products or smoking. In the efficacy trials, erythema following system removal was typically seen in about 17% of patients, some edema in 4%, and dropouts due to skin reactions occurred in 6% of patients.

Patients should be instructed to promptly discontinue the Habitrol treatment and contact their physicians if they experience severe or persistent local skin reactions at the site of application (e.g., severe erythemo, pruritus or edema) or a generalized skin reaction (e.g., urticaria, hives, or generalized rash).

Skin Disease: Habitrol systems are usually well tolerated by patients with normal skin, but may be irritating for patients with some skin disorders (atopic or eczematous dermatitis).

Cardiovascular or Peripheral Vascular Diseases: The risks of nicotine replacement in patients with certain cardiovascular and peripheral vascular diseases should be weighed against the benefits of including nicotine replacement in a smoking cessation program for them. Specifically, patients with coronary heart disease (history of myocardial infarction and/or angina pectoris), serious cardiac arrhythmias, or vasospastic diseases (Buerger's disease, Prinzmetal's variant angina) should be carefully screened and evaluated before nicotine replacement is prescribed.

Tachycardia occurring in association with the use of Habitrol treatment was reported occasionally. If serious cardiovascular symptoms occur with Habitrol treatment, it should be discontinued.

Habitrol treatment should generally not be used in patients during the immediate post-myocardial infarction period, patients with serious arrhythmias, and patients with severe or worsening angina pectoris.

Renal or Hepatic Insufficiency: The pharmacokinetics of nicotine have not been studied in the elderly or in patients with renal or hepatic impairment. However, given that nicotine is extensively metabolized and that its total system clearance is dependent on liver blood flow, some influence of hepatic impairment on drug kinetics (reduced clearance) should be anticipated. Only severe renal impairment would be expected to affect the clearance of nicotine or its metabolites from the circulation (see CLINICAL PHARMACOLOGY, Pharmacokinetics).

Endocrine Diseases: Habitrol treatment should be used with caution in patients with hyperthyroidism, pheochromocytoma or insulin-dependent diabetes since nicotine causes the release of catecholamines by the adrenal medulla.

Peptic Ulcer Disease: Nicotine delays healing in peptic ulcer disease; therefore, Habitrol treatment should be used with caution in patients with active peptic ulcers and only when the benefits of including nicotine replacement in a smoking cessation program outweigh the risks.

Accelerated Hypertension: Nicotine constitutes a risk factor for development of malignant hypertension in patients with accelerated hypertension; therefore, Habitrol treatment should be used with caution in these patients and only when the benefits of including nicotine replacement in a smoking cessation program outweigh the risks.

Information for Patients
A patient instruction sheet is included in the package of Habitrol systems dispensed to the patient. It contains important information and instructions on how to use and dispose of Habitrol systems properly. Patients should be encouraged to ask questions of the physician and pharmacist.

Patients must be advised to keep both used and unused systems out of the reach of children and pets.

Drug Interactions
Smoking cessation, with or without nicotine replacement, may alter the pharmacokinetics of certain concomitant medications.

May Require a Decrease in Dose at Cessation of Smoking	Possible Mechanism
Acetaminophen, caffeine, imipromine, oxazepom, pentazocine, propranolol, theophylline	Deinduction of hepotic enzymes on smoking cessation
Insulin	Increase of subcutaneous insulin absorption with smoking cessation
Adrenergic ontaganists (e.g., prazasin, labetolal)	Decrease in circuloting cotecholomines with smoking cessation
May Require an Increase in Dose at Cessation of Smoking	**Possible Mechanism**
Adrenergic agonists (e.g., isoproterenol, phenylephrine)	Decrease in circulating catecholamines with smoking cessation

Carcinogenesis, Mutagenesis, Impairment of Fertility
Nicatine itself daes not oppear to be a corcinogen in labaratory animols. However, nicatine and its metabolites increased the incidence of tumars in the cheek pauches af hamsters and forestomach of F344 rats, respectively, when given in cambination with tumor-initiotars. One study, which cauld nat be replicated, suggested that catinine, the primory metabolite af nicotine, may cause lymphoreticular sorcamo in the large intestine in rats.

Nicatine and catinine were not mutagenic in the Ames *Salmonella* test. Nicatine induced repairable DNA damage in an *E. coli* test system. Nicotine was shawn ta be genotoxic in a test system using Chinese hamster avary cells. In rats and rabbits, implantation can be deloyed or inhibited by a reduction in DNA synthesis that appears ta be caused by nicatine. Studies have shawn a decreose in litter size in rats treated with nicotine during gestatian.

Pregnancy Category D (see WARNINGS)
The harmful effects of cigarette smoking an maternal and fetal health are clearly estoblished. These include law birth weight, an increased risk of spantaneous abartion, and increased perinatal martality. The specific effects af Habitral treatment an fetal develapment are unknawn. Therefore, pregnant smokers should be encouraged ta attempt cessation using educational and behaviaral interventians before using pharmacological appraaches.

Spantaneous abartion during nicatine replacement therapy has been reported; as with smaking, nicatine as a cantributing factar cannat be excluded.

Habitral treatment should be used during pregnancy anly if the likelihaad of smaking cessation justifies the patential risk of use af nicotine replacement by the patient, who may cantinue to smake.

Teratogenicity
Animal Studies: Nicotine was shawn ta produce skeletal abnarmalities in the offspring af mice when given doses toxic ta the dams (25 mg/kg/day IP or SC).

Human Studies: Nicotine teratogenicity has not been studied in humans except as a camponent of cigarette smake (each cigarette smaked delivers abaut 1 mg af nicatine). It has not been passible ta conclude whether cigarette smaking is teratagenic ta humans.

Other Effects
Animal Studies: A nicatine bolus (up ta 2 mg/kg) to pregnant rhesus monkeys caused acidasis, hypercarbia, and hypotensian (fetal and maternal cancentrations were about 20 times those achieved after smoking 1 cigarette in 5 minutes). Fetal breathing movements were reduced in the fetal lamb after intravenous injectian af 0.25 mg/kg nicatine to the ewe (equivalent ta smoking 1 cigarette every 20 seconds for 5 minutes). Uterine blood flaw was reduced abaut 30% after infusion of 0.1 mg/kg/min nicotine for 20 minutes to pregnant rhesus monkeys (equivalent ta smaking about six cigarettes every minute for 20 minutes).

Human Experience: Cigarette smaking during pregnancy is associated with an increased risk of spantaneous abartian, law-birth-weight infants and perinatal martality. Nicotine and carbon monoxide are considered the most likely mediators af these autcames. The effects of cigarette smaking an fetal cardiavascular parameters has been studied near term. Cigarettes increased fetal aortic blood flow and heart rate, and decreased uterine blaad flaw and fetal breathing mavements. Habitral treatment has nat been studied in pregnant humans.

Labor and Delivery
Habitrol systems are not recommended ta be left on during labar and delivery. The effects af nicatine an the mather ar the fetus during labar are unknown.

Nursing Mothers
Caution should be exercised when Habitrol therapy is administered ta nursing women. The safety af Habitrol treatment in nursing infants has nat been examined. Nicotine passes freely into breast milk; the milk-to-plasma ratia averages 2.9. Nicotine is absorbed orally. An infant has the ability ta clear nicotine by hepatic first-pass clearance; however, the efficiency of removal is probably lawest at birth. The nicotine concentrations in milk can be expected to be lower with Habitral treatment when used as directed than with cigarette smaking, as maternal plasma nicotine concentrations are generally reduced with nicatine replacement. The risk af exposure of the infant to nicatine from Habitrol systems shauld be weighed against the risks associated with the infant's exposure to nicotine from continued smoking by the mother (passive smoke exposure and contamination of breast milk with other campanents of tobacco smoke) and from Habitrol systems alone ar in combination with continued smaking.

Pediatric Use
Habitrol systems are nat recommended for use in children because the safety and effectiveness af Habitrol treatment in children and adolescents wha smoke have not been evaluated.

Geriatric Use
Forty-eight patients aver the age af 60 participated in clinical trials of Habitral therapy. Habitral therapy appeared ta be as effective in this age group as in younger smokers.

ADVERSE REACTIONS
Assessment of adverse events in the 792 patients wha participated in controlled clinical trials is complicated by the occurrence of GI and CNS effects of nicotine withdrawal as well as nicotine excess. The actual incidences af both are confounded by concurrent smoking by many of the patients. In the trials, when reporting adverse events, the investigators did not attempt to identify the cause af the symptam.

Topical Adverse Events
The most camman adverse event associated with topical nicotine is a short-lived erythema, pruritus, or burning at the application site, which was seen at least once in 35% of patients an Habitrol treatment in the clinical trials. Local erythema after system removal was noted at least once in 17% of patients and local edema in 4%. Erythema generally resolved within 24 hours. Cutaneous hypersensitivity (contact sensitization) accurred in 2% af patients an Habitral treatment (see PRECAUTIONS, Allergic Reactians).

Probably Causally Related
The following adverse events were reported more frequently in Habitrol-treated patients than in placebo-treated patients or exhibited a dase response in clinical trials.

Digestive system – Diarrhea,* dyspepsia.*
Mouth/Tooth disorders – Dry mouth.
Musculoskeletal system – Arthralgia,* myalgia.*
Nervous system – Abnarmal dreams,† samnalence.†

Frequencies for 21 mg/day system
*Reported in 3% ta 9% of patients.
†Reported in 1% ta 3% af patients.
Unmarked if reported in <1% af patients.

Causal Relationship Unknown
Adverse events reported in Habitral- and placebo-treated patients at about the same frequency in clinical trials are listed below. The clinical significance af the association between Habitrol treatment and these events is unknawn, but they are reported as alerting information for the clinician.

Body as a whole – Allergy,† back pain.†
Cardiovascular system – Hypertension.†
Digestive system – Abdaminal pain,† constipation,† nausea,* vomiting.
Nervous system – Dizziness,* concentration impaired,† headache (17%), insomnia.*
Respiratory system – Cough increased,† pharyngitis,† sinusitis.†
Uragenital system – Dysmenorrhea.*

Frequencies for 21 mg/day system
*Reported in 3% ta 9% of patients.
†Reported in 1% ta 3% af patients.
Unmarked if reported in <1% af patients.

DRUG ABUSE AND DEPENDENCE
Habitrol systems are likely ta have a low abuse potential based on differences between it and cigarettes in four characteristics commonly considered important in contributing to abuse: much slower absorption, much smaller fluctuations in blood levels, lawer blood levels of nicotine, and less frequent use (i.e. once daily).

Dependence an nicatine polacrilex chewing gum replacement therapy has been reported. Such dependence might also occur from transference to Habitrol systems of tobacco-based nicotine dependence. The use af the system beyand 3 months has not been evaluated and should be discauraged.

To minimize the risk of dependence, patients should be encouraged ta withdraw gradually fram Habitrol treatment after 4 ta 8 weeks of usage. Recommended dose reduction is ta pragressively decrease the dase every 2 ta 4 weeks (see DOSAGE AND ADMINISTRATION).

CAUTION: Federal law prohibits dispensing without prescription.

C92-1 (Rev. 2/92)

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References:
1. Data on file, Basel Pharmaceuticals.
2. Sachs DPL. Advances in smoking cessation treatment. In: Simmons DH, ed. *Current Pulmonology.* St Louis, Mo: Mosby-Year Book Inc; 1991;12:139-198.

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Illinois peds react to vaccine program

IMMUNIZATION: Pediatricians comment on a plan for the federal government to buy all childhood vaccines and distribute them free. By Gina Kimmey

[CHICAGO] Three out of every 10 U.S. 2-year-olds are not fully immunized, and in some inner cities only one in 10 children receives age-appropriate immunizations. The number of U.S. measles cases rose from fewer than 1,500 in 1983 to 27,672 in 1990.

In Illinois the figures aren't much better. Forty-three percent of Illinois children outside of Chicago are not properly immunized, and only 29 percent of Chicago children receive all of the recommended vaccines, according to the Illinois Department of Public Health.

Why aren't children being immunized? It comes down to multiple barriers: inadequate access to health care, missed opportunities for giving vaccines and lack of public awareness of the need. But there are also problems of resources, location of immunization sites, funding and lack of insurance. In an attempt to tackle the immunization crisis, the Clinton administration is considering a plan under which the federal government and the states would buy all childhood vaccines and distribute them free to public clinics and private doctors' offices. Longstanding Illinois State Medical Society House of Delegates policy supports the concept of increased government funding for immunization of schoolchildren.

> *There are many reasons why children aren't immunized; cost is one of them. This plan must be carried out in such a way that cost is not an impediment.*
>
> **JAY E. BERKELHAMER, MD**

The administration said the plan could lead to universal immunization because the cost of vaccines, which has risen sharply in the past decade, would no longer be a barrier. According to the American Academy of Pediatrics, the cost to fully immunize a child in a public health clinic in 1982 was $6.69, but by 1991 that figure had risen to $91.20, and last year the private-sector price for required vaccines was $198, not including administrative charges.

Jay E. Berkelhamer, MD, president of the Illinois chapter of the American Academy of Pediatrics, said a national plan would be consistent with the AAP's position, but several specifics need to be addressed. "There are many reasons why children aren't immunized; cost is one of them. This plan must be carried out in such a way that cost is not an impediment." He also noted that this plan shouldn't be used to set up immunization "way stations"; a quick trip to a public clinic for immunizations doesn't meet all the child's health care needs. "The whole child needs to be treated; there are many aspects of child development that can be addressed only during periodic visits to the doctor," he said.

Dr. Berkelhamer also expressed concern over the federal government's being the only buyer of vaccines. "If the federal government is buying all vaccines at the federal contract price, there is a serious threat of vaccine suppliers' going out of business." He said suppliers can offer the government such low prices on vaccines because they charge everyone else inflated prices to make up the difference. If this plan is to go into effect, Dr. Berkelhamer said government must ensure an adequate supply of vaccines and unhindered research and development.

Mark Rosenberg, MD, a Barrington pediatrician who worked on a similar vaccine program for Illinois, said he thinks it is much more sensible to approach the issue from a federal level. Dr. Rosenberg said that Illinois, like many states, ran into an obstacle because the vaccine companies were not interested in selling to the state at the federal contract price.

"This is a wonderful program and will help families who can't afford immunizations get back to their doctor's office," said Dr. Rosenberg. "It is very important to put patients back into the doctor's office. The public clinics are overwhelmed." He also expressed concern about a possible lack of funds for R & D, but said that at the federal level, the U.S. Centers for Disease Control and Prevention and the National Institutes of Health have the knowledge to work through those issues.

"Our No. 1 priority is getting all kids immunized for all required vaccinations

(Continued on page 23)

IN HYPERTENSION—
A BALANCE
OF GENTLENESS AND POWER
Make It Your Choice for a Lifetime–write DAW
ONCE-DAILY
Calan® SR
verapamil HCl
SUSTAINED-RELEASE CAPLETS
THE GENTLE GIANT

The recommended starting dosage for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food. Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY
Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.
Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.
Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing), dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.
Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, maculae, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.
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EDITORIAL

Judge's abuse of power was wrong

It was wrong and an abuse of power to throw a physician and his attorneys in jail just because the doctor refused to answer a question. That was the unanimous opinion of three appellate court justices regarding last April's jailing of ISMIE-insured James V. Vest, MD, of Belleville, his Exchange-provided attorney and his personal attorney.

The appellate judges said the trial judge – who held Dr. Vest and his attorneys in contempt of court and ordered them to jail – was wrong for five separate reasons. Not the least of those was that he considered no alternatives to jailing Dr. Vest, even after Dr. Vest's attorneys explained that the doctor had patients to see that afternoon.

The appellate court said that the contempt charge was completely inappropriate and that trial judges should never impose such a sanction without significant thought and research. Further, one of the justices said he knows of no other situation in the law in which someone who is not sued and not charged with a crime is subjected to both the expense of hiring an attorney and the threat of jail simply for failing to answer a question. He pointed out that the information the plaintiff sought could have been gleaned through other discovery procedures and through the affidavit of merit required to file medical malpractice lawsuits.

Dr. Vest's road to jail began in April 1992, when he was deposed by an attorney representing the estate of a deceased patient. The attorney, James Cook, had not filed suit and had summoned Dr. Vest under Rule 224, an Illinois Supreme Court rule that permits testimony "for the sole purpose of ascertaining the identity of one who may be responsible for damages."

During the deposition, Dr. Vest declined, on the advice of counsel, to answer a question pertaining to the patient's treatment, because he and his attorneys believed it was beyond the scope of Rule 224. The judge found Dr. Vest and his lawyers in contempt of court and ordered them to jail.

They were released when the appeals court stayed the contempt citation pending oral arguments. At the oral arguments, Dr. Vest, flanked by physician colleagues and his Exchange attorney, appeared before the appellate court.

So a physician was wrongly thrown in jail when his patients needed him. Then he had to travel to another county for another day in court. All this because of a plaintiff's attorney's abuse of a rule and a trial judge's abuse of power. It strikes us that the plaintiff's attorney was fishing and the trial judge gave him license to fish wherever he wanted. They both got caught, and we would rejoice except that Dr. Vest's patients were the ones on the hook.

PRESIDENT'S LETTER

The spirit is willing, but the flesh may be weak here

By Arvind K. Goyal, MD



People who'll have to serve and eat the plan – the physicians and their patients – are away from the kitchen.

A Michigan mother caught short on groceries for her family rushed to the store. With her, she took along 6-year-old Tommy. "Hey, Mom, can I tell you something?" puffed Tommy on the way. "Not right now; I'm too busy," the mother shut him up. At the store, Tommy tried again, "Hey Mom ... " "Don't bother me when I'm trying to think," the mother interrupted. Finally, at home, Tommy again spoke, "Now can I tell you?" "Oh, yes, what is it?" the exasperated mother gave in. "Your pants are unzipped!"

Such is the concern physicians all around the country now have when they try to tell the new people in Washington to listen to them – for later may be too late!

Health care reform needs to occur – and quickly – so that the gridlock in health care is broken. Everybody agrees. The quality and the choices for our patients are preserved. Costs are controlled. And everybody's care is paid for. Things that need to happen to get there are understood, that is, by most who care to understand.

The details based on these same "principles" can be messy, especially when party politics, campaign contribution lists, "the economy, stupid," and re-election plans are factored in. A brand-new president who promised a reform plan within the first 100 days of his administration remains accountable to the electorate. And expeditiously, he did act after taking his oath of office. No question. He did so by appointing his "better half" to head a purely administrative task force to generate such a plan. In a democracy, anybody can become president – whoever said democracy doesn't have drawbacks? Not so, being a president's wife. That has nothing to do with democracy. The first lady is said to be intelligent, informed, willing, on her marks and ready to go. And she indeed has access to the president. Yet, she may not be accountable to anybody else!

While that plan is cooking, people who'll have to serve and eat that plan – the physicians and their patients – are away from the kitchen. Nobody has been told what's up – when, where and what will be served. Vaguely defined and easily misunderstood concepts – the global budgets, managed competition, tax caps on insurance benefits, and such – have been leaked through the press periodically. Will the current system be canned altogether in favor of an untested new recipe? Will the government want to eat more than it can chew? Will there be something in the new proposals to eliminate waste imposed by paperwork, government regulation, huge executive salaries, and profits of not-for-profit hospitals, so-called managed care organizations, and peer review and utilization review companies? Will there be more dollars available for preventive services, patient education on healthy lifestyle choices and standardization of insurance market practices? And then, the million-dollar question: Will there be caps on noneconomic awards in malpractice cases? The waiting is tough – every minute seems like an hour!

Once Mr. and Mrs. President's blueprint for a health care reform plan does come out, the final question would then be asked: Will it pass muster in Congress and the media? Reforms are generally most unpopular where most needed!

Your state medical society supports the AMA in its efforts to get at the table and on with its work on behalf of all Americans. The principles of health care reform as developed by your House of Delegates last April have been delivered to Mrs. Clinton. Efforts are under way to make further contacts with those who matter in the White House and the Congress – that is, via former Gov. Jim Thompson and his team under the Washington Presence program. A trip to Washington, D.C., by your elected leadership is planned this month in pursuit of that same mission. Appropriate committees at the state medical society remain engaged in developing such legislative options as could be pursued in Springfield. As an old proverb goes, The farmers work on Sunday if the ox is in the ditch. Your society's vigilant work on your behalf continues!

POINT

In defense of pharmaceutical pricing

By Charles Fry

I read with great interest Dr. Goyal's recent president's letter "Rx drug costs – out of sight, out of mind."

The premise of your editorial seems to be that the research and development efforts of the pharmaceutical industry are not worth the results unless provided at little or no cost. You suggest that only "caring physicians" and "well-meaning pharmacists" are sensitive to the impact the cost of prescription drugs has on consumers – implying that the industry isn't concerned about how much patients must pay for prescription medicine. I do not propose to speak for the industry, but I would like to respectfully disagree.

Searle, which has long appreciated the plight of the indigent, instituted the Searle Patient In Need program in 1986. This program provides Searle medication at no cost to those who cannot afford it. There is no means test, and the attending physician determines which patients to enroll. To date, Searle has provided more than 5 million certificates. Under the Searle Patient Promise program, any Searle medication that fails to achieve the desired therapeutic outcome may be returned to Searle for a full refund on the most current prescription.

On the cost of drugs, to focus only on the dollars charged for a product ignores the incalculable good the product creates in health care. Just recall when the iron lung was the only treatment for polio or when surgery was the only treatment for ulcers and cardiovascular disease. Modern drugs and vaccines have changed that.

A recent Battelle study estimates that more than 50 percent of all future medical progress over the next 25 years will directly result from pharmaceutical discoveries. With the *average* cost of bringing a new therapy from discovery to market pegged at somewhere between $250 million to $400 million, it seems fair to ask, Why do new therapies cost so much to develop? My response is, Can we as a society afford *not* to continue to invest in new drug research? Although today only one out of every 5,000 research alerts makes it to market, I believe the answer is that we must continue to look for new and improved therapeutic agents. Ultimately, society must answer this profound cost question.

Although medicine is sorely tested by its own government problems, physicians must appreciate that the industry's future is in jeopardy because of political intervention. Legislation passed in 1990 forces a company that wishes to do business with the federal/state Medicaid programs to pay "rebates" – a tax by any other name. In Illinois alone, for 1993, this tax will result in a $20 million windfall to the state – dollars normally used to fund R & D.

In fact, the drug pricing issue is tied up in current insurance coverage policies. At present, more than 30 percent of all out-of-pocket health care costs are for pharmaceuticals, and more than 70 percent of pharmaceutical costs are truly out-of-pocket. This "discrimination" against outpatient drug coverage is the key to the problem your patients point to when they say they cannot continue to purchase their medication.

As an industry, we support creating an outpatient drug program for Medicare. The methodology of such a program will require the input of many of the key players in the health care delivery system. In this regard, Searle would welcome the opportunity to work with the Illinois State Medical Society in arriving at such a solution.



Charles Fry *is the corporate vice president for public affairs at G.D. Searle & Co. in Chicago.*

COUNTERPOINT

In response to Searle's arguments

By Arvind K. Goyal, MD

Many, many thanks for your informative letter outlining your perspective on pharmaceutical prices and their impact on health care costs. I am pleased to learn of Searle's commitment to prescriptions for the needy, as well as the Searle Patient Promise program, which should be made known to more of our patients.

As a family physician treating real patients every day, I know that a growing number of patients are struggling – often unsuccessfully – to meet escalating drug costs. These people, sick and worried enough to have come to my office for help, are unable to restore their good health because medication costs are beyond their financial ability.

As you state, insurers could cover such costs in all, or at least wider, circumstances. But I would submit that perhaps one reason insurers cannot or do not do so is rapidly escalating drug costs. And in any case, the increased premiums your proposal would generate would still end up raising health insurance premiums for everyone. That would obviously make health insurance less affordable and add to the rolls of the uninsured.

One could hardly pick up the business news over the last few years without finding a story on the large profits of pharmaceutical drug companies – and more recently on your industry's current price posturing to prepare for leaner times ahead under a newly reformed health care system. And these reports seem to bear out the concerns of my own patients as they lament the costs of drugs they need.

You argue that pharmaceutical prices are reasonable because they often constitute an alternative to more costly surgical care. Yet, this in itself does not justify huge markups on prescription drugs.

I do understand that drug companies face ever-growing liability costs, as do physicians and other health providers. I know of the huge regulatory costs you face in researching potentially promising pharmaceuticals and then gaining FDA acceptance. I am aware and appreciative of the wonderful medical miracles that drug therapy and research can produce. But in light of these facts, as you so aptly ask in your letter, does the industry charge too much for its products? Perhaps not – but many indicators and public perceptions would seem to point the other way – grounds, in my view, for some scrutiny within and outside your industry.

On behalf of Illinois physicians, I, too, would welcome the opportunity to work with you and your colleagues at Searle and other pharmaceutical companies on the many troubling issues confronting medical care today. And that effort is sure to benefit our patients and your consumers.



Arvind K. Goyal, MD, *is a family physician in Rolling Meadows and president of the Illinois State Medical Society.*

Resolutions due March 23

The Illinois State Medical Society's House of Delegates Annual Meeting is scheduled for April 23-25, and the deadline for submission of resolutions is fast approaching. To be considered, resolutions must be received at ISMS headquarters prior to the close of business on March 23; a postmark of March 23 is not sufficient. All resolutions received after this date will be considered under the rules of late resolutions.

Resolutions should be addressed to Raymond E. Hoffmann, MD, Speaker of the ISMS House of Delegates, 20 N. Michigan Ave., Suite 700, Chicago, Ill. 60602, Attn: Mr. Ott. ■



"I've looked at your numbers, doctor. You qualify as a nonprofit organization."

What the governors want

The National Governors' Association said a restructured health care system should ideally include at least the following tenets:

- Universal access;
- A standardized and federally organized consumer information base on quality and price of providers;
- Federally organized national outcomes research to establish clinical practice models;
- Federal minimum standards for the regulation of health insurance;
- State-organized purchasing cooperatives;
- Tort and liability reform standards;
- A single national claim form;
- A core benefits package;
- Limitations on tax deductibility of health insurance;
- Primary and preventive care. ■

Governors adopt health care policy

STATE ACTION: The nation's governors applauded Medicaid concessions offered by President Clinton but want more flexibility in funding Medicaid. By Tamara Strom

[WASHINGTON] The National Governors' Association unanimously adopted health care reform policy Feb. 1 calling for universal access and cost containment.

Developed by the NGA Task Force on Health Care, the governors' policy supports the concept of managed competition now popular in government circles. The governors define managed competition as a framework within which the government spurs provider competition to promote quality health care and hold down costs.

Included in the NGA policy is an endorsement of tort and liability reform. The policy statement says these reforms should be established at the federal level, but the governors said they "must have the flexibility to design and regulate their own programs that meet the federal standards or further limit liability."

Although Illinois Gov. Jim Edgar supports the NGA proposal – especially the focus on preventive health care, managed care and tort reform – the governor is waiting to see what action Congress takes at the national level before Illinois undertakes major revisions of its health system. Edgar also endorses the concepts in the NGA plan that call for a federal framework for reform and flexibility for states to enact aspects of reform, said Katherine Sullivan, associate director of the State of Illinois Washington Office.

Illinois is in a different position than other states because it is not currently putting forward a broad-based reform proposal of its own, Sullivan explained. In the meantime, Edgar's Health Care Reform Task Force, which first addressed the health facilities Medicaid assessment program, now is examining options for long-range reform.

Specifically, the NGA proposal calls for health care reform that includes "state-organized purchasing cooperatives," a minimum benefits package and limits on tax deductions for health insurance premiums, according to NGA. The health care policy stresses the need for greater emphasis on primary and preventive care, and underscores the necessity for federal regulation of health insurance.

To implement managed competition, creation of a national health care board comprising state and local government representatives is recommended by NGA. In addition, any managed competition policy must allow for meeting the unique health care needs of the country's inner cities and rural communities, the governors said.

Recognizing that national health care reform will take time to enact, the NGA policy says that states "should be encouraged to move ahead in advance of full implementation of the national reforms and should be given the tools necessary to be successful." This includes liberalizing the rules governing self-insured companies. The governors said any reform plans they undertake should regulate employers now exempted by ERISA.

IN RELATED ACTIONS, the governors adopted policy "asking for greater leeway in funding Medicaid," Sullivan said. President Clinton "accepted a number of the governors' recommendations" regarding Medicaid waivers, she added.

Clinton directed the U.S. Department of Health and Human Services to

(Continued on page 21)

Blue Cross® Blue Shield®

REPORT FOR *Illinois Physicians*

More than 900,000 members participate in Blue Cross and Blue Shield of Illinois' PPO Programs. The following is the PPO Hospital Network effective January 1, 1993. If you would like a listing of PPO Physicians, please contact the Provider Assistance Unit at (312) 938-7340.

ILLINOIS

Aledo	Mercer County Hospital
Alton	Alton Memorial Hospital
Anna	Union County Hospital
Arlington Hts	Northwest Community Hospital
Aurora	Mercy Center for Health Care Services
Barrington	Good Shepherd Hospital
Belleville	St. Elizabeth Hospital
Belvidere	Highland Hospital, Inc.
	St. Joseph's Hospital
Benton	Franklin Hospital
Berwyn	MacNeal Hospital
Bloomington	BroMenn Regional Medical Center
	BroMenn Lifecare Center
	Eureka Community Hospital
	St. Joseph Medical Center
Blue Island	St. Francis Hospital
Breese	St. Joseph's Hospital
Canton	Graham Hospital
Carbondale	Memorial Hospital of Carbondale
Carlinville	Carlinville Area Hospital
Carmi	Carmi Township Hospital
Carrollton	Thomas H. Boyd Memorial Hospital
Carthage	Memorial Hospital
Centralia	St. Mary's Hospital
Centreville	Centreville Township Hospital
Chester	Memorial Hospital
Chicago	Bethany Hospital
	Charter-Barclay Hospital
	Chicago Osteopathic Hospital
	Children's Memorial Hospital
	Columbus Hospital
	Cook County Hospital
	Grant Hospital of Chicago
	Holy Cross Hospital
	Humana Hospital - Michael Reese
	Illinois Masonic Medical Center
	Jackson Park Hospital
	LaRabida Children's Hospital and Research Center
	Louis A. Weiss Memorial Hospital
	Mercy Hospital & Medical Center
	Mount Sinai Hospital & Medical Center
	Northwestern Memorial Hospital
	Our Lady of the Resurrection Medical Center
	Ravenswood Hospital Medical Center
	The Rehabilitation Institute of Chicago
	Resurrection Hospital
	Roseland Community Hospital
	Schwab Rehabilitation Hospital
	South Chicago Community Hospital
	St. Elizabeth's Hospital
	St. Joseph Hospital
	St. Mary of Nazareth Hospital
	Swedish Covenant Hospital
	University of Chicago Medical Center
Clifton	Central Community Hospital
Clinton	John Warner Hospital
Danville	United Samaritans Medical Center
Decatur	St. Mary's Hospital
DeKalb	Kishwaukee Community Hospital
Des Plaines	Holy Family Hospital
Dixon	Katherine Shaw Bethea Hospital
Downers Grove	Good Samaritan Hospital
DuQuoin	Marshall Browning Hospital Association
East St. Louis	St. Mary's Hospital
Effingham	St. Anthony's Memorial Hospital
Eldorado	Ferrell Hospital
Elgin	Sherman Hospital
Elmhurst	Elmhurst Memorial Hospital
Eureka	Eurkea Community Hospital
Evanston	Evanston Hospital
	St. Francis Hospital
Evergreen Park	Little Company of Mary Hospital
Fairbury	Fairbury Hospital
Fairfield	Fairfield Memorial Hospital
Flora	Clay County Hospital
Forest Park	Riveredge Hospital
Freeport	Freeport Memorial Hospital
Galena	Galena-Stauss Hospital
Galesburg	St. Mary's Hospital
Geneseo	Hammond-Henry District Hospital
Geneva	Delnor-Community Hospital
Gibson City	Gibson Community Hospital
Glendale Hts	Glen Oaks Medical Center
Glenview	Glenbrook Hospital
Greenville	Edward A. Utlaut Memorial Hospital
Harrisburg	Harrisburg Medical Center
Harvey	Ingalls Memorial Hospital
Havana	Mason District Hospital
Hazel Crest	South Suburban Hospital
Herrin	Herrin Hospital
Highland	St. Joseph's Hospital
Highland Park	Highland Park Hospital
Hillsboro	Hillsboro Hospital
Hinsdale	Hinsdale Hospital
Hoffman Estates	Humana Hospital
Hoopeston	Hoopeston Community Memorial Hospital
Hopedale	Hopedale Medical Complex
Jacksonville	Passavant Memorial Area Hospital
Jerseyville	Jersey Community Hospital
Joliet	Silver Cross Hospital
	St. Joseph Hospital
Kankakee	Riverside Medical Center
Kewanee	Kewanee Hospital
LaGrange	LaGrange Memorial Hospital
Lawrenceville	Lawrence County Memorial Hospital
Lincoln	Abraham Lincoln Memorial Hospital
Litchfield	St. Francis Hospital
Macomb	McDonough District Hospital
Marion	Marion Memorial Hospital
Maryville	Anderson Hospital
Mattoon	Sarah Bush Lincoln Health Center
McHenry	Northern Illinois Medical Center
McLeansboro	Hamilton Memorial Hospital
Melrose Park	Westlake Community Hospital
Mendota	Mendota Community Hospital
Metropolis	Massac Memorial Hospital
Moline	Trinity Medical Center - East Campus
Monmouth	Community Memorial Hospital
Monticello	John & Mary E. Kirby Hospital
Morris	Morris Hospital
Morrison	Morrison Community Hospital
Mount Carmel	Wabash General Hospital
Mount Vernon	Crossroads Community Hospital
	Good Samaritan Regional Health Center
Murphysboro	St. Joseph Memorial Hospital
Nashville	Washington County Hospital
Normal	BroMenn Regional Medical Center
	BroMenn Lifecare Center
	Eureka Community Hospital
	St. Joseph Medical Center
Oak Lawn	Christ Hospital
Oak Park	Oak Park Hospital
	West Suburban Hospital Medical Center
Olney	Richland Memorial Hospital
Olympia Fields	Olympia Fields Osteopathic Medical Center
Ottawa	Community Hospital of Ottawa
Palos Heights	Palos Community Hospital
Pana	Pana Community Hospital
Paris	Paris Community Hospital
Park Ridge	Lutheran General Hospital
	Parkside Lutheran Hospital
Pekin	Pekin Memorial Hospital
Peoria	St. Francis Hospital Medical Center
Peru	Illinois Valley Community Hospital
Pinckneyville	Pinckneyville Community Hospital
Pittsfield	Illini Community Hospital
Pontiac	St. James Hospital
Princeton	Perry Memorial Hospital
Quincy	Blessing Hospital
	St. Mary Hospital
Red Bud	St. Clement Hospital
Robinson	Crawford Memorial Hospital
Rochelle	Rochelle Community Hospital
Rock Island	Trinity Medical Center - West Campus
Rockford	Rockford Memorial Hospital
	St. Anthony Medical Center
	Swedish American Hospital
Rosiclare	Hardin County General Hospital
Rushville	Sarah D. Culbertson Memorial Hospital
Salem	Public Hospital of the Town of Salem
Sandwich	Sandwich Community Hospital
Savanna	Savanna City Hospital
Shelbyville	Shelby Memorial Hospital
Sparta	Sparta Community Hospital
Spring Valley	St. Margaret's Hospital
Springfield	Memorial Medical Center
Staunton	Community Memorial Hospital Association
Sterling	CGH Medical Center
Streator	St. Mary's Hospital
Sycamore	Sycamore Hospital
Taylorville	St. Vincent Memorial Hospital
Tuscola	Douglas County Jarman Memorial Hospital
Urbana	Covenant Medical Center Urbana
Vandalia	Fayette County Hospital
Watseka	Iroquois Memorial Hospital
Waukegan	Saint Therese Medical Center
West Frankfort	U.M.W. of A. Union Hospital
Winfield	Central DuPage Hospital
Wood River	Wood River Township Hospital
Woodstock	Memorial Hospital for McHenry County

INDIANA

Crown Point	St. Anthony Medical Center
Dyer	Our Lady of Mercy Hospital
East Chicago	St. Catherine Hospital
Evansville	Deaconess Hospital
	Welborn Memorial Baptist Hospital
Gary	Methodist Hospital
	St. Mary Medical Center
Hammond	St. Margaret's Hospital
LaFayette	St. Elizabeth Hospital & Medical Center
Merrillville	Methodist Hospital
Michigan City	Memorial Medical Center
Munster	The Community Hospital
South Bend	St. Joseph's Hospital
Terre Haute	Terre Haute Regional Hospital

IOWA

Clinton	Samaritan Health Systems
Davenport	Mercy Hospital
Dubuque	Finley Hospital
Keokuk	Keokuk Area Hospital

MISSOURI

Chesterfield	St. Lukes Hospital - West
Hannibal	Hannibal Regional Hospital
St. Louis	Barnes Hospital
	Cardinal Glennon Children's Hospital
	Christian Hospital NW
	Jewish Hospital
	SSM Rehabilitation Institute
	St. Anthony's Medical Center
	St. John's Mercy
	St. Louis Children's Hospital
	St. Louis University Hospital
	St. Mary's Health Center

WISCONSIN

Beloit	Beloit Memorial Hospital
Burlington	Memorial Hospital of Burlington
Fond Du Lac	St. Agnes Hospital
Kenosha	Kenosha Memorial Hospital
Monroe	St. Clare Hospital of Monroe
Waupun	Waupun Memorial Hospital

(2/26/93)

ISMIE Update



Exchange Q & A

PAGE 10



Malpractice Roundup

PAGE 10

Upcoming court decision may expose physicians to products liability

BREACH OF WARRANTY: The rules that traditionally govern business liability may now apply to the tort or personal injury area. By Tony Sullivan

[CHICAGO] Physicians and other health care and medical service providers in Illinois may face exposure in a new area of liability – products liability – if an Illinois appellate court supports a 1990 circuit court ruling. Attorneys presented their oral arguments to the Illinois Appellate Court, 1st Judicial District, in late January. The court is currently reviewing the case and is expected to offer its written opinion in two to three months, according to attorneys involved in the case.

In the case, *Garcia vs. Edgewater Hospital*, a Cook County circuit court in 1990 found the hospital guilty of breach of warranty for supplying a defective heart valve used in an implant operation. The malfunctioning valve forced the surgeon to reopen the patient and replace the defective valve, significantly prolonging the surgery. The patient, a Jehovah's Witness, refused blood transfusions and ultimately died.

The patient's estate sued the surgeon for negligence, and the heart valve manufacturer and the hospital for "breach of warranty," a products liability theory. The manufacturer settled with the plaintiff before trial, but the hospital and the surgeon went to court. The circuit court ruled against the plaintiff in the professional negligence claim involving the surgeon but in favor of the plaintiff in the breach of warranty claim against the hospital. The hospital is appealing the decision.

At issue is whether health care service providers – and, by extension, related service providers such as physicians – can be sued for breach of warranty. To date, Illinois law has protected service providers in such cases.

PLAINTIFFS' ATTORNEYS can pursue three theories of products liability to prove their cases, explained David Hall, a malpractice defense attorney with Lord, Bissell & Brook in Chicago. Hall defended Edgewater Hospital in the circuit court case and is also involved in the appeal. The first theory is negligence. "This is similar to professional negligence, such as medical malpractice," Hall said. "It says that somehow the manufacturer or person involved with developing the product negligently had something to do with it."

In the circuit court case, the plaintiff's attorney argued that the hospital was at the end of the distribution line and acted as a product "retailer." "He argued that maybe we did something negligently in handling this product or maybe that we had a duty to inspect it before it was inserted, and that we violated that duty by not inspecting it," said Hall. But the plaintiff's attorney couldn't generate any evidence on the theory of defendant fault, so he withdrew that claim the night before the trial.

THE TWO REMAINING THEORIES are not based on fault, Hall said. The first is "strict liability in tort," a theory that developed through Illinois case law and is based on a landmark case from the 1970s. "The case concluded that it is good public policy to hold manufacturers and certain people in the distribution chain responsible for unreasonably dangerous products that cause harm," Hall explained.

The Illinois General Assembly didn't like that ruling, however. So it established an exception in

(Continued on page 10)

Specialties with the highest suit frequency*

Specialty	Percent of all PIAA claims	Percent of all ISMIE claims
Obstetrics/ gynecology	15	11.55
Internal medicine	13	9.75
Orthopedic surgery	11	9.74
General surgery	12	9.10
Radiology	6	7.71

*As of June 30, 1992
Source: Illinois State Medical Insurance Services, Physician Insurers Association of America

Practice closing, damages limitations explained



In closing a medical practice, the actions that must be taken immediately are to provide coverage for patients by another physician, contact patients in hospitals and other facilities, notify the attorney and accountant, send a death/moving notice to newspapers, notify medical staffs of hospitals and other facilities, and inform pharmacies, organizations with which the physician had contracts, and insurance agents. For more information, see the Illinois State Medical Society brochure "Closing a Medical Practice."

THE FOLLOWING information regarding damages is from Ill. Rev. Stat. 1991, ch. 110, par. 13-212:

No action for damages for injury or death against any physician, dentist, registered nurse or hospital duly licensed under the laws of this State, arising out of patient care shall be brought more than 2 years after the date on which the claimant knew, or through the use of reasonable diligence should have known, or received notice in writing of the existence of the injury or death for which damages are sought in the action, whichever of such date occurs first, but in no event shall the action be brought more than 4 years after the date on which the act occurred or omission or occurrence alleged. There are some exceptions to the above statement. If the action accrued to an individual under the age of 18 years, no action for damages for injury or death against a physician, dentist, registered nurse or hospital duly licensed under the laws of this State, arising out of patient care shall be brought more than 8 years after the date on which the alleged act or omission or occurrence occurred; provided, however, that in no event may the cause of the action be brought after the person's 22nd birthday. Further, if the person entitled to bring action is under legal disability or imprisoned at the time the cause of action accrues, the period of limitations does not begin to run until the disability is removed or the person ceases to be imprisoned.

Explanation: No action for damages for injury or death against any physician, dentist, registered nurse or hospital licensed in Illinois can be brought more than two years from the date the problem was discovered. In no event may the action be brought more than four years after the date on which the alleged act, omission or occurrence took place. There are some exceptions to the above statement. If the action occurred to an individual under the age of 18 years, no action for damages for injury or death against the respective individual/entity can be brought more than eight years after the date on which the alleged act or omission or occurrence took place. In no event may the cause of the action be brought after the person's 22nd birthday. For example, for a minor who is an infant, action may be brought no more than eight years after the alleged act, whereas for a minor who is 16 or older, action may not be brought after the person's 22nd birthday. Further, if the action happened when the person

(Continued on page 11)

EXCHANGE Q & A

Q. What advantages does a physician-owned malpractice insurance company offer?

A. Because practicing Illinois physicians own the Exchange, policyholders have advantages other companies don't offer. Physicians are active in all company activities, which allows policyholders to talk with peers and colleagues about questions and problems. Physician Review and Evaluation Panels review prospective applicants and current policyholders to determine insurability, and a Physician Review Committee reviews claims and suits to make "defend or settle" decisions. Physician input in these areas makes the Exchange truly "a doctor's company."

The Exchange also offers loss prevention and risk management services developed by Illinois physicians to policyholders, groups and hospitals, and provides physician network representatives in almost every Illinois hospital to answer questions and resolve problems.

Q. What can I do to ensure effective telephone communications between my staff and patients?

A. Physicians should make certain that everyone in the office recognizes the importance of good communication and proper telephone procedures. No call or complaint should be taken lightly, and physicians should remind staff not to discount patient symptoms. Although symptoms may seem routine to office staff, they may cause both physical and emotional discomfort, including fear and embarrassment, to patients.

When developing telephone protocol, physicians should include the following:

- Develop specific written guidelines detailing procedures for patient access to the doctor. Also, guidelines should be made for appointment scheduling. Specify what information staff must obtain from the patient for the physician to make an accurate medical assessment of how soon the patient should be seen. Define which calls should be referred to you immediately.
- Respect patient confidentiality. If a caller prefers not to give personal information to staff, this preference should be honored.
- Staff should document every incoming phone call, recording the caller's name, phone number, the date and time of the call, the staff person who spoke with the caller, the reason for the call and the action taken. Copies of these messages, if clinically pertinent, should be kept in the patient's record.
- The physician should personally and immediately attend to all calls in which a dissatisfied patient threatens to sue, contact a lawyer or seek a new physician. Try to reassure the patient of your sincere, personal interest. Any threat of litigation should be immediately reported to the Exchange.
- Require a caller who is a lawyer or from an insurance company to state the specific reason for the call. Staff should not disclose any medical information without the patient's signed release and the physician's approval.

Q. Is the Exchange in a financially stable position?

A. The Exchange is financially sound. The company has been able to survive when other companies have not, because it is experienced and has not been afraid to make tough decisions in order to remain a viable company. The Illinois Department of Insurance reviews and regulates the finances and operations of the Exchange. The Exchange Investment Committee, composed of physicians, makes investment decisions so that money will be available to pay losses when it's needed. The ISMIE internal audit function, unique among physician-owned insurance companies, monitors the company's claims and underwriting activities to make sure that premium dollars are spent wisely and efficiently.

Q. What should I do if an obviously dissatisfied patient has not paid a bill?

A. There are few better ways to provoke a lawsuit than sending an overdue notice to an already dissatisfied patient. However, forgiving legitimate charges could be interpreted as an admission of having provided substandard care.

Rather than developing strict bill collection policies, consider each case individually. Ask your staff to report all instances of fee disputes to you and be prepared to discuss fees directly with patients. Physicians should personally review all contested bills as well as those scheduled to go to collection. Physicians should also personally adjust bills. ■

Exchange surveying policyholders

Policyholders are the most important concern at the Illinois State Medical Inter-Insurance Exchange. The Exchange wants to evaluate the "Physician First Service" initiative's success to date, so in February, it is sending all policyholders a questionnaire regarding professional liability and Exchange services. In addition, the Exchange is surveying some policyholders by phone. All responses will be strictly confidential.

An independent consulting firm will tabulate the responses, and *Illinois Medicine* will share the results in an upcoming issue.

In a letter to policyholders, Harold L. Jensen, MD, Exchange board chairman, thanked policyholders for taking their time to help the Exhange be the best it can be. ■

Products liability

(Continued from page 9)

the state's Code of Civil Procedure. "In our code there is a provision that says we don't like the idea of your sticking the person at the end of the distribution line – like the hospital, the store or the retailer – for something bad the manufacturer did," Hall said.

"So there is an exception built into the Illinois law," continued Hall, "that says if someone at the end of the distribution line is named in a products liability action and that individual or company can name the manufacturer of the product and bring that manufacturer into the case, then the retailer or other entity at the end of the distribution line can get out of the case."

With more procedures being done in physicians' offices these days, doctors may become the target of products liability lawsuits if a product goes bad.

The plaintiff's attorneys in the circuit court case tried to apply the strict liability in tort theory in that case. "They were saying that Edgewater Hospital was part of the distribution chain, so it was liable for the injury that resulted from the defective heart valve," Hall said.

To counter that argument, Hall invoked the exception contained in the code. "We named the manufacturer. We argued that we did nothing wrong to damage the product, so we should get out of the case. On the eve of the trial, the plaintiff's attorneys abandoned the strict liability of tort theory [in addition to the negligence theory] because he knew we had a good defense."

However, the third theory available to plaintiffs' attorneys in products liability cases – breach of warranty – proved indefensible. "This is a newfangled way to go after people under products liability in the health care setting," Hall said. Lawsuits involving breach of warranty have occurred for many years, but accusing hospitals or physicians of breaching the warranty of a product "is a more creative, novel theory with very little law on it."

Breach of warranty is a theory included in the Uniform Commercial Code, the collection of all statutes relating to sales, transactions and contracts. "Now they [the plaintiffs' attorneys] are trying to bring the rules that traditionally apply to the business arena to the tort or personal injury arena," Hall said.

The UCC contains a provision that states that a good or a product for sale must be "merchantable and fit for its intended purpose." In short, it must be able to do what the manufacturer says it will do. If it doesn't, a suit can be filed for breach of warranty. In *Garcia*, the plaintiff's attorney argued that a heart valve is supposed to work, but it didn't work, so the manufacturer and "retailer" were liable for breach of warranty.

Illinois attorneys have used the breach of warranty argument in case law involving health care providers in only two cases, according to Hall. One case

MALPRACTICE ROUNDUP

Consultant physicians' responsibilities

When responding to a consultation, consultant physicians accept the same risks and legal responsibilities as do primary physicians. However, according to *The Letter*, a publication of the Louisiana Medical Mutual Insurance Co., consulting physicians can take steps to reduce their risks.

First, make every effort to discuss the case with the primary physician before and after the consultation and be thoroughly familiar with the patient's medical record. Avoid implying criticism such as, "I should have been called sooner," and ask the primary physician before calling another consultant. Communicate with the patient and his or her family and always inform relatives of your role in the patient's care. When the consult is complete, document it in the medical records, including the date and time of the consult. ■

Liability concerns affect access to care

According to statistics published by the American Medical Association, access to health care services in the United States is being reduced by the professional liability climate. On average, physicians' professional liability premiums tripled in the 1980s, making them the fastest-growing component of practice expenses during the decade. On average, liability insurance premiums for family physicians practicing obstetrics are double the premiums paid by family physicians who don't provide those services. And one-third of U.S. physicians avoid particular areas of medical practice, even though they are qualified, because of malpractice insurance costs.

The liability climate also affects availability of services. Between 1988 and 1991, liability premiums paid by community health centers rose from $30 million to $60 million. Premiums now consume about 10 percent of all federal funds allocated to the centers. As a result, the centers have cut services and patients must wait longer for appointments. Further, the National Association of Community Health Centers estimates that at least 500,000 more patients could be served if health center funds spent on liability insurance were used for direct patient care. ■

involved a downstate hospital. The defense attorney did not raise all his available defenses in that case, so the case was silent on many of the defenses available to health care providers in alleged breach of warranty cases, Hall said.

In the second case a plaintiff sued Planned Parenthood for breach of warranty for distributing birth control pills that allegedly didn't work. The jury decided in favor of the plaintiff. This case illustrated the key test involved in most breach of warranty cases: the predominant purpose test. It stands as the main defense argument that the appellate court is considering in *Garcia*.

THIS TEST REQUIRES determining the predominant purpose of any transaction: Is it a product, in which case breach of warranty can apply, or is it a service, in which case breach of warranty cannot apply? "In the Planned Parenthood case, the jury felt that the birth control pills were really the predominant thing that the plaintiff went there for," Hall said. "The counseling she received at the same time was incidental to the transaction.

"In my case, the patient did not go to the hospital to buy a heart valve," Hall said. "She went there to get better. She went to get services. She went to get heart treatment. The valve was incidental to the service of fixing her up. In addition, the valve was the more modest [part] of the cost. So our theory is that this whole transaction was a transaction of hospital or health care services – medical treatment – and the valve was just incidental to that. Therefore, UCC should not apply."

If the appellate court supports the circuit court ruling, it could have far-reaching effects on health care and medical service providers because of the wide range of products they use in treatment. Providers would face potential products liability lawsuits involving needles, breast implants, penile implants, sutures, drugs and all other products used in health care and medical treatment.

"If the product is passed to the customer – the patient – in the hospital setting, I would assume that plaintiffs' attorneys will focus their attention on the hospitals," Hall said. But with more procedures being done in physicians' offices these days, doctors may become the target of products liability lawsuits if a product goes bad. "The doctor could arguably be viewed as the last link in the distribution chain."

In a related development, a bill was introduced in the Illinois General Assembly in January by Sen. James "Pate" Philip (R-Elmhurst), president of the Illinois Senate, and Sen. David N. Barkhausen (R-Lake Forest). S.B. 3 would create the Product Liability Improvement Act and would apply to civil actions against manufacturers and product sellers for harm caused by a product.

The bill would create a presumption that a defendant – that is, a manufacturer or "seller" – is not liable for a product if the product was approved by, or was in compliance with, standards promulgated by a federal or state agency responsible for the product's safety. That presumption could be rebutted only by "clear and convincing evidence" that the manufacturer or product seller intentionally withheld material information regarding the product's safety. Punitive damages would be limited to three times the amount of actual damages.

Despite the apparent weight *Garcia* carries with the Illinois health care and medical community, Hall is unwilling to call it a potential landmark case. "The case has the potential of clearing up some of the law on the issue of breach of warranty and its applicability to the health law area," he said. "It's a very gray area. It's hard to predict an outcome on any given case." ■

Practice closing

(Continued from page 9)

was under a legal disability or imprisoned, then the period of limitations does not begin to run until the disability is removed or the person ceases to be imprisoned.

According to Ill. Rev. Stat. 1991, ch. 110, par. 13-215, if a person fraudulently conceals the cause of such action, the action may be commenced at any time within 5 years after the person entitled to bring the same discovers that he or she has such cause of action.

According to Ill. Rev. Stat. 1991, ch. 91½, pars. 801-817, under the Mental Health and Developmental Disabilities Confidentiality Act, damages may be brought against a physician at any time. ■

Editor's note: This is part of a series covering medical-legal issues written by the Illinois State Medical Society Medical Legal Council. The information addresses legal concerns that physicians most commonly express to ISMS. It is intended to serve only as a general guide for physicians, not as specific legal advice.



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PHYSICIAN EMPATHY

Medical schools teach the personal touch

A little training goes a long way in helping future doctors communicate and empathize with their patients.

BY JANICE ROSENBERG

Illinois medical schools are finding room in their busy curriculums for subjects that have little to do with science and everything to do with doctoring. Along with anatomy and biochemistry are courses aimed at producing sensitive physicians. Today's students study interviewing techniques, practice communication skills and learn to empathize with their patients. These new lessons are part of traditional required courses such as physical diagnosis as well as the focus of intense, elective seminars.

"There is a tremendous sensitivity in medical school curriculums these days that did not exist in the 1930s when I started out," said Joseph B. Kirsner, MD, Louis Block Distinguished Service Professor of Medicine at the University of Chicago. "The issues around ethics and the decisions around various procedures are far more sensitive than they used to be, so there is a semiformal way of teaching students to be sensitive to these aspects of the sick person."



JOHN MCNULTY

Courses in sensitivity training have come on the scene gradually over the last 20 years. In the 1970s, increasingly knowledgeable patients began demanding that physicians talk to them. At the same time, high-tech methods of diagnosis and treatment made physician-patient interactions less personal. Partly to address these issues, medical schools introduced humanities departments.

Some of the most popular systems for teaching sensitivity use "standardized patients" – actors who role-play the part of patients. "We use standardized patients to supplement the variety of patients and situations that a student sees," said Reed G. Williams, PhD, interim associate dean for undergraduate medical education at the University of Illinois. "Students can watch tapes of an interview they've done. They have time to reflect on it, talk to faculty, and go back and do the interview again."

At Southern Illinois University Medical School, standardized patients have been used since 1973. "During the first year, they are our major tool for teaching notions of empathy, sensitivity and communication skills," said Roger Robinson, assistant dean of students for the Carbondale campus. "It's been a tradition of our school to make these things important."

Faculty at the Stritch School of Medicine at Loyola University are developing a pilot program to introduce standardized patients in a way that conforms to the school's philosophy. "We believe that the medical system revolves around the patient, not the physician," said Ralph P. Leischner, MD, senior associate dean. "We explore the doctor-patient relationship in an effort to improve it for the patient."

WHEN CLINICAL WORK BEGINS IN physical diagnosis courses, standardized patients are again employed by many schools. "We use them to help evaluate the students' history taking and physical examination skills," said Holly Humphrey, MD, assistant professor of medicine at the U of C. Second-year students learn how to talk and listen to patients. They learn the proper ways of touching and robing patients, and interacting with other hospital staff members.

Second-year students at SIU participate in a full week of situational studies conducted by the medical humanities department. Students inform standardized patients that they have cancer. They interact with standardized patients who describe marital problems or admit they've contemplated suicide.

PHYSICIAN EMPATHY

Four years ago the U of I set up its Clinical Performance Center. "During the second year, the center uses standardized patients to provide a series of structured clinical experiences designed to ensure that students have dealt with a wide variety of situations and that they are competent to deal with them," said Dr. Williams.

According to Eve Veis, curriculum coordinator at Northwestern University Medical School, where second-year students attend a course called "Society and Medicine," students are "eager" to be sensitive. "These kinds of courses tell you how to talk to a patient," said second-year student Lori Beth Kolb. "It's good that the courses start before you're seeing actual patients. They prevent you from putting up a shield and living behind medical terms."

You can run a whole series of courses, but it's the role model of the teacher and patient-physician relationship that really has a long-term impact.

AS STUDENTS BEGIN THEIR clerkships in the third year, sensitivity training continues. In 1992, Northwestern introduced a week-long course called "Introduction to the Clinical Clerkships." The course is designed to sensitize students to patients' feelings and to help students feel comfortable as they begin working on the wards.

"In scenarios and lectures we emphasize that patients should never wait very long at a doctor's convenience," said William Pearce Jr., MD, associate professor of surgery at Northwestern. "We stress the need for patients to maintain some modesty in the hospital. And we point out that patients are basically scared a lot of the time."

At the U of C, during the third-year core rotation in the department of medicine, students' professional attitudes and behaviors toward patients are evaluated. At the U of I, clinical ethics rounds often focus on communication problems. At SIU, students spend two full weeks in each of the last two years studying humanities and ethics.

"You're made aware of the social and ethical issues," said Kristin Malaker, a fourth-year student at SIU. "That's an important part of medicine that a lot of times is forgotten."

During the final year of training, elective courses predominate. In 1992, the U of C offered "Advanced Interviewing Techniques" for the first time. "We dealt with difficult doctor-patient relationships," said Dr. Humphrey. "We used scenarios and tried to teach students how to work professionally through situations with angry, hostile, manipulative or dependent patients."

During the clerkship years, Stritch continues to impress on students the primary objective of valuing the patient. "We sensitize them to the patient's needs and develop critical skills of interviewing and physical examination in smaller groups," said Dr. Leischner.

Overall, Illinois medical schools are making an effort to produce caring, sensitive physicians. Nevertheless, SIU's Robinson worries that students may become hardened during the grind of the third and fourth years. "They are tired," he pointed out. "They want things to go right, and if patients aren't responding 'properly,' then they're not perceived as 'good' patients and empathy can go to hell."

That's when role models begin to assume their greatest importance. "I think the best way to teach is by example," said Dr. Kirsner. "We need more physicians who espouse this sort of thing. This makes a tremendous impression on students. You can run a whole series of courses, but it's the role model of the teacher and patient-physician relationship that really has a long-term impact." ■

JOHN MCNULTY



Smiles emanate from February Employee of the Month

[CHICAGO] Service with a smile isn't a cliché if you're referring to February's Employee of the Month Colleen O'Connell.

Physicians and staffers alike know O'Connell for her competence and creativity in planning medical society and insurance services functions. She is the person they call to make their business-related travel arrangements – often with 11th-hour requests to get them somewhere else right away.

In fact, O'Connell's nominator for the award praised her grace under pressure, even when she gets a call to arrange hospitality service for a physician meeting at a moment's notice. "Last-minute requests never fluster her," the nominator said, adding that no request is ever "too much" or "out of the question."

O'Connell puts "just the right touch" on every event she plans, said Betty Duffy, Illinois State Medical Society Vice President of Meeting and Travel Services. O'Connell joined ISMS in 1989 and was promoted to assistant meeting planner in May 1992.

Duffy characterized the interview when O'Connell first sought employment with the medical society as "probably the shortest in history – 10 minutes and I knew I had to have her."

During the Feb. 1 award ceremony at ISMS headquarters, O'Connell acknowledged her fellow employees for their support and effort in making her job easier. "I want to thank everyone I work with, which is everybody!"

All permanent, full-time ISMS and Illinois State Medical Insurance Services employees, with the exception of senior management, are eligible for the Employee of the Month award. To nominate a staff member, contact the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■


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February Employee of the Month Colleen O'Connell was praised for her grace under pressure.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

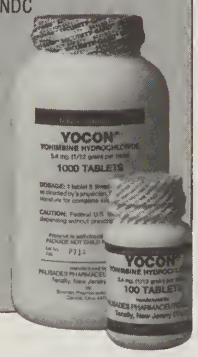
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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OBITUARIES

* indicates ISMS member
** indicates member of ISMS Fifty Year Club

Ames
Frank Ames, MD, of Jacksonville, died Oct. 16, 1992, at the age of 57. Dr. Ames was a 1961 graduate of the University of Illinois College of Medicine, Chicago.

***Boyd**
David L. Boyd, III, an internist from Champaign, died Sept. 28, 1992, at the age of 35. Dr. Boyd was a 1983 graduate of the University of Tennessee College of Medicine, Memphis.

***Brewer**
Thomas E. Brewer, MD, a family physician from Taylorville, died Oct. 16, 1992, at the age of 48. Dr. Brewer was a 1970 graduate of the University of Illinois College of Medicine, Chicago.

****Calosio**
Richard T. Calosio, MD, a surgeon from Joliet, died Nov. 5, 1992, at the age of 84. Dr. Calosio was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

****Dohrmann**
George O. Dohrmann Jr., MD, a family physician from Chicago, died Oct. 22, 1992, at the age of 76. Dr. Dohrmann was a 1941 graduate of the Pritzker School of Medicine of the University of Chicago.

****Gibbs**
Frederic A. Gibbs, MD, a neurologist from Wilmette, died Oct. 18, 1992, at the age of 89. Dr. Gibbs was a 1929 graduate of Johns Hopkins University School of Medicine, Baltimore.

Jacobson
Leon O. Jacobson, MD, of Chicago, died Sept. 20, 1992, at the age of 80. Dr. Jacobson was a 1939 graduate of the Pritzker School of Medicine of the University of Chicago.

Jennings
Lester Jennings, DO, of Flossmoor, died Oct. 9, 1992, at the age of 42. Dr. Jennings was a 1973 graduate of Kirksville College of Osteopathic Medicine, Kirksville, Mo.

****Koesterer**
Philip J. Koesterer, MD, a general practitioner from Mascoutah, died Sept. 23, 1992, at the age of 73. Dr. Koesterer was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

****Linden**
John M. Linden, MD, a general practitioner from Freeport, died Oct. 13, 1992, at the age of 83. Dr. Linden was a 1933 graduate of the University of Wisconsin Medical School, Madison.

***McCarthy**
Daniel J. McCarthy, MD, a surgeon from Palos Heights, died Oct. 17, 1992, at the age of 62. Dr. McCarthy was a 1955 graduate of the University of Illinois College of Medicine, Chicago.

****Moses**
Eugene Moses, MD, a family physician from Rock Island, died Oct. 18, 1992, at the age of 83. Dr. Moses was a 1934 graduate of Medizinische Fakultaet der Universitaet Basel, Basel, Switzerland.

****Quattlebaum**
Edwin G. Quattlebaum, MD, a surgeon from Rockford, died Oct. 16, 1992, at the age of 93. Dr. Quattlebaum was a 1926 graduate of the Medical University of South Carolina College of Medicine, Charleston, S.C.

****Scott**
William M. Scott, MD, a general practitioner from Bement, died Oct. 21, 1992, at the age of 79. Dr. Scott was a 1939 graduate of Northwestern University Medical School, Chicago.

Simon
Marshall U. Simon, MD, an otolaryngologist from Winnetka, died Sept. 18, 1992, at the age of 70. Dr. Simon was a 1945 graduate of the University of Illinois College of Medicine, Chicago.

***Sircar**
Amito K. Sircar, MD, a surgeon from Woodstock, died Sept. 22, 1992, at the age of 67. Dr. Sircar was a 1951 graduate of Calcutta Medical College, Calcutta University, Calcutta, India.

***Sloan**
David L. Sloan, MD, a radiologist from Herrin, died Oct. 19, 1992, at the age of 53. Dr. Sloan was a 1965 graduate of the University of Illinois College of Medicine, Chicago.

Stull
John De Gar Stull, MD, of Olney, died July 23, 1992, at the age of 79. Dr. Stull was a 1938 graduate of Washington University School of Medicine, St. Louis.

****Teitelman**
S. Lloyd Teitelman, MD, a surgeon from Chicago, died Nov. 16, 1992, at the age of 80. Dr. Teitelman was a 1937 graduate of Northwestern University Medical School, Chicago.

****Tufo**
Gustave F. Tufo, MD, a general practitioner from Chicago, died April 1, 1992, at the age of 90. Dr. Tufo was a 1924 graduate of the General Medicine College, Chicago.

Weinbaum
Abraham M. Weinbaum, MD, of Chicago, died Sept. 12, 1992, at the age of 99. Dr. Weinbaum was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

***Welsh**
Daniel E. Welsh, of Chicago, died Sept. 24, 1992, at the age of 24. Mr. Welsh was a student at Rush Medical College, Chicago.

***Wojtowycz**
Stefan Wojtowycz, MD, of Plano, died Oct. 2, 1992, at the age of 73. Dr. Wojtowycz was a 1949 graduate of Medizinische Fakultaet der Ludgwig Maximiliams Universitaet, Muenchen, Bayern, Germany.

****Woody**
Howard G. Woody, MD, an orthopedic surgeon from Springfield, died Nov. 11, 1992, at the age of 82. Dr. Woody was a 1941 graduate of Rush Medical College, Chicago.

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IDPR DISCIPLINES

November 1992

Gedimimas K. Balukas, Chicago – physician and surgeon license indefinitely suspended for gross negligence.

Jeffrey Bohn, Rockford – physician and surgeon license reprimanded and fined $2,500 after allegedly using misleading advertisement.

Irwin Brown, Chicago – physician and surgeon license issued and placed on indefinite probation for answering affirmatively to a personal history question on his application.

Richard S. Cook, Chicago – physician and surgeon license and controlled substance license indefinitely suspended after multiple violations of the Medical Practice Act.

Parakrama DeSilva, Chicago – physician and surgeon license reprimanded and fined $1,000 for dishonorable, unethical, and unprofessional conduct.

John L. Froiland, Chicago – physician and surgeon license placed on probation for eighteen months for criminal conviction of vendor fraud.

Norman D. Hungness, Sheldon – physician and surgeon license reprimanded and fined $2,500 after violating a previous Department ordered probation.

Victoria Nosovitsky, Mount Vernon – physician and surgeon license placed on indefinite probation after answering affirmatively to a personal history question on her application.

Jerry A. Ponitch, Tempe, AZ – physician and surgeon license placed on indefinite probation and controlled substance license indefinitely suspended after being disciplined in the State of Arizona.

Thomas C. White, Rockford – physician and surgeon license reprimanded and fined $5,000 for gross negligence.

December 1992

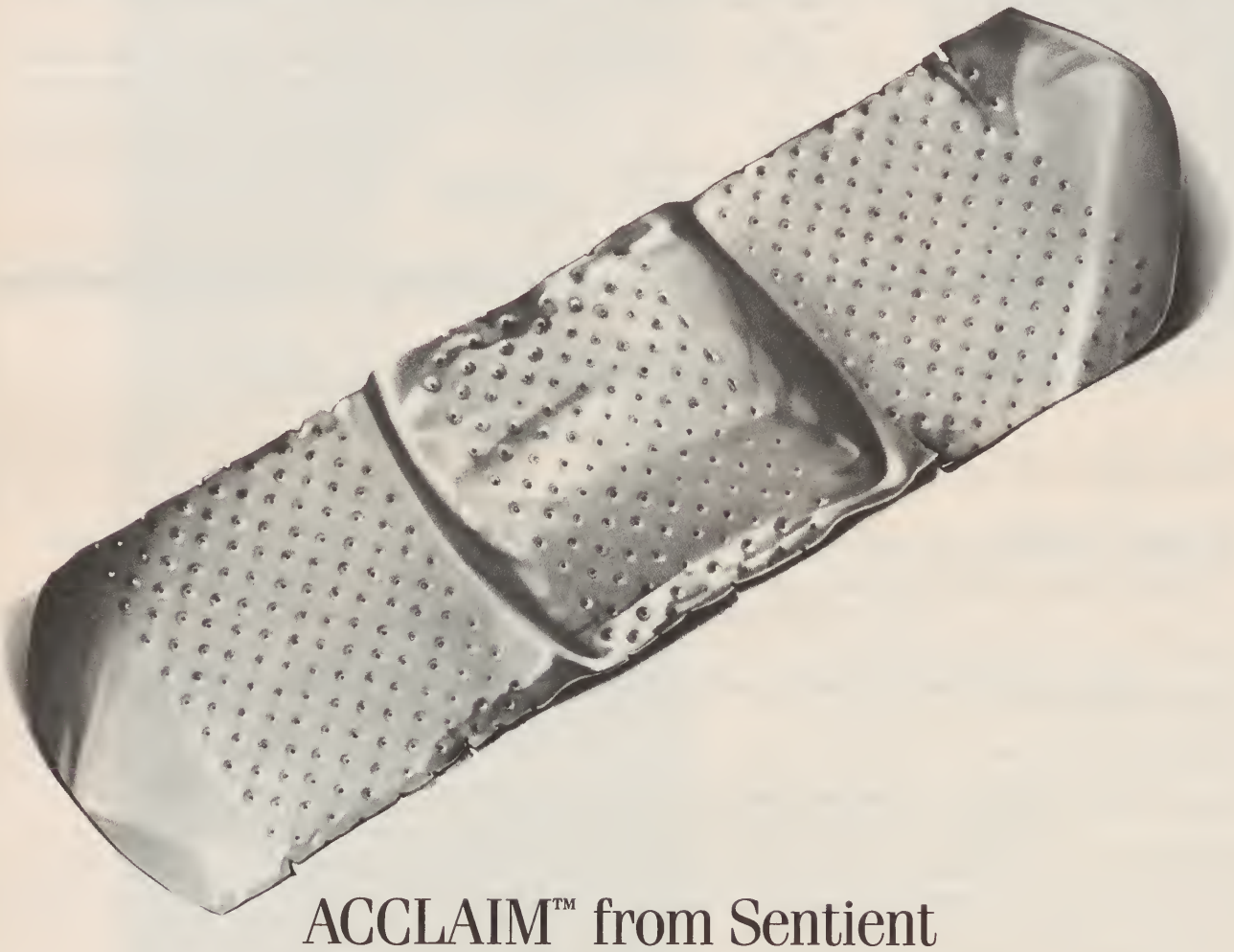
Dennis Coventon, Augusta – physician and surgeon license placed on probation for three years after failing to keep adequate records for patients and failed to keep controlled substance logs for drugs dispensed to office patients.

Stephen Willig, Lebanon – physician and surgeon license placed on indefinite probation after being disciplined in the State of Missouri.

Wynne Lenci a/k/a Superson, Downers Grove – physician and surgeon license suspended for eighteen months followed by two years probation; controlled substance license indefinitely suspended for a minimum of three years after multiple violations of the Medical Practice Act.

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

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In addition, **ISMS President Arvind K. Goyal, MD, is available for membership** calls the first Wednesday of every month, 11 a.m. to noon. Use the toll-free or Chicago number above and ask for ext. 1333. ■

Vest contempt ruling

(Continued from page 1)

under Illinois Supreme Court Rule 224. The rule, as interpreted by the Fifth District Appellate Court in its latest decision, limits discovery to the "identification of responsible persons" including the names and addresses of individuals who could be named in a future suit.

Dr. Vest, an Illinois State Medical Inter-Insurance Exchange policyholder, and his attorneys were jailed when he refused to answer a question from plaintiff's attorney Bruce Cook specifically regarding treatment of the patient in question, Melvin J. Roth. Roth died of sepsis in May 1991 at St. Elizabeth's Hospital in Belleville. The appellate court determined that Cook's question was beyond the scope of Rule 224.

"I couldn't believe it," Dr. Vest told *Illinois Medicine*. "The appellate court's opinion was so positive it made the ordeal worthwhile for Illinois doctors." Dr. Vest said there was a "day and night difference in fairness" between the appellate judges' decision and Radcliffe's.

Despite the victory, Dr. Vest is wary that the ordeal is not over. "I suspect Cook will end up suing us all," he said, calling Cook a "vindictive man who is not used to being told 'no.'"

Exchange defense attorney Cremeens said she was very pleased and relieved by the ruling. "I knew that if we lost we were going back to jail," she said. "We need a celebration down here."

Cremeens added that she was surprised at the appellate judges' harshness toward Radcliffe's actions. Taking unusual interest in the case, all three justices wrote opinions, and all three agreed that the defendants should not have been jailed. In his opinion, Justice William A. Lewis wrote of Radcliffe, "I am sure that anything we say in criticism of his ruling or conduct probably will not be as bad as the judge's own criticism of his ruling during the night or early morning hours immediately after his decision." He added that Radcliffe, "in his quest to learn the truth from the doctor, became an advocate for the petitioner and lost his impartiality and his patience with the respondent and his attorneys."

Notorious for their plaintiff verdicts, St. Clair County courts are embroiled in politics, Cremeens said. Cook and Radcliffe, she explained, had been partners in the same law firm, which could explain Radcliffe's adamance that Dr. Vest be jailed. Lewis also wrote that Radcliffe had two courses of action if he charged the three with contempt – to fine them or to send them to jail. Lewis said Radcliffe may have insisted on incarceration because a fine would not get the question answered.

PRESIDING JUSTICE Charles W. Chapman was also swayed by Cook's and Radcliffe's conduct during the deposition. Chapman found that although the defendants' behavior was earnest and respectful throughout the deposition, comments made by both Cook and Radcliffe indicated they had few qualms about detaining Dr. Vest and interrupting his patient and hospital schedule. Chapman said the jailing "perpetuated the aura of intimidation" Cook created during the deposition with such comments as, "You [Dr. Vest] are going to end up in the slammer."

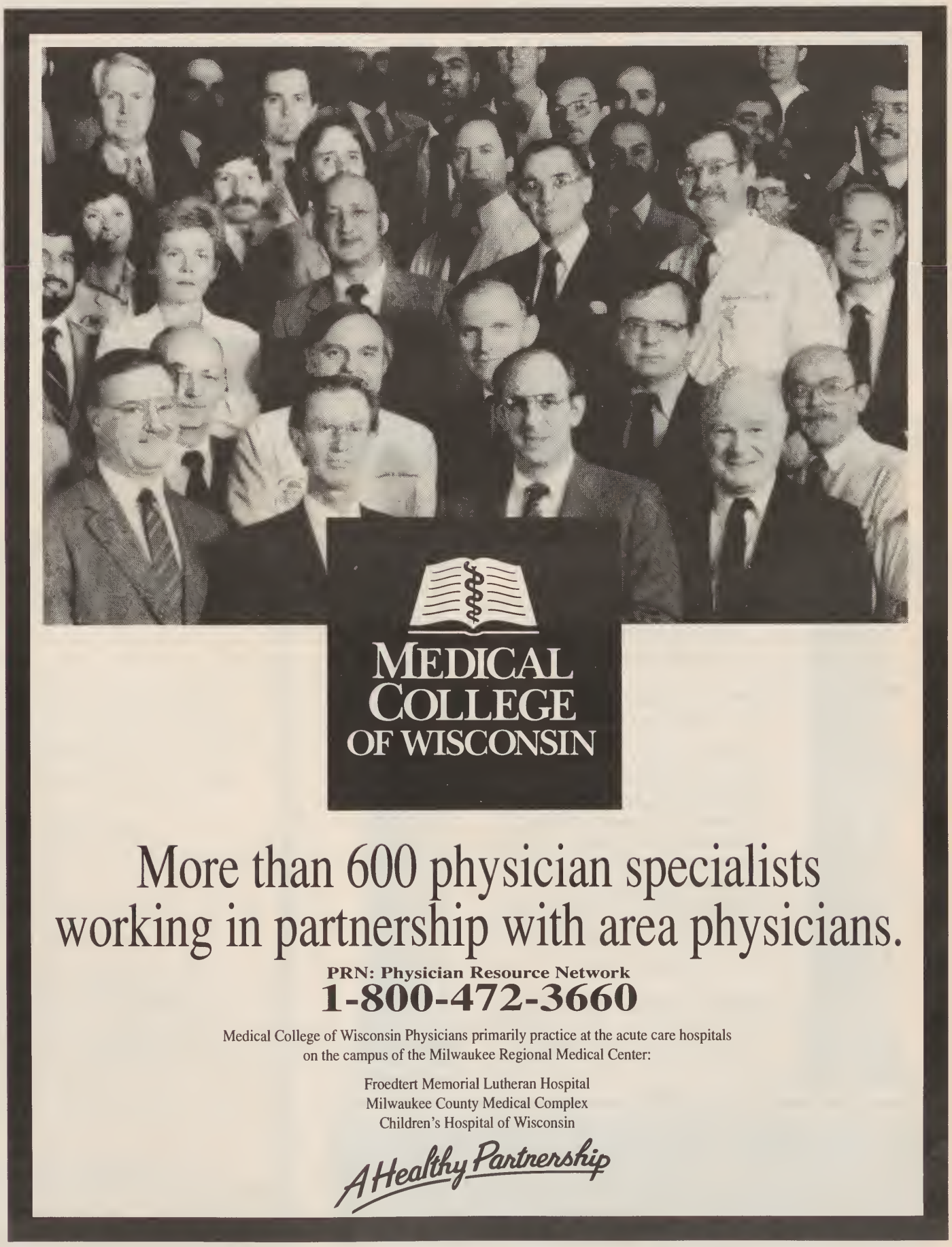
The three appellate justices also considered the legal implications of the use of Rule 224. In his opinion, Chapman wrote that the trial court was wrong in its legal analysis in five ways:

1. The language of Rule 224 does not allow discovery "as extensive as the petitioner sought."
2. "Committee comments to Rule 224 are contrary to the court's construction of the rule."
3. Previous cases invoking Rule 224 "do not support the court's interpretation" of the rule.
4. The Illinois Supreme Court's denial of the respondent's petition for supervisory order did not serve as an approval of the court's management of the proceedings.
5. The "factual circumstances of the case made it clear that the use of Rule 224 was both unnecessary and unwarranted."

In a dissenting opinion, Justice Richard P. Goldenhersh wrote that the two other justices' interpretation of the rule was "too restrictive and works to defeat its intent." Goldenhersh's argument focused on the semantics of the rule as it is written, and he wrote that the majority overemphasized the use of the term "identity" and underemphasized the use of the term "responsibility," thus changing the rule's meaning.

The appellate court agreed, however, that the most alarming aspect of the contempt ruling was that Dr. Vest was unable to see patients while he was detained in the St. Clair County Jail for five hours, until an emergency stay was granted, causing him to cancel 35 appointments and miss hospital rounds. "No emergency existed that required immediate incarceration; and yet it was ordered," Chapman wrote.

The Illinois State Medical Society had filed an amicus curiae brief in support of Dr. Vest. Cremeens said she does not believe the decision would be reversed if appealed to the Illinois Supreme Court. Cook could not be reached for comment on whether an appeal is planned. ■



MEMBERS IN THE NEWS

William R. Panje, MD, of Chicago, has been listed in *Good Housekeeping* magazine as one of the top cancer specialists in the United States. A board-certified ENT/otolaryngologist, Dr. Panje was one of 400 surgeons and radiation oncologists named by department chairmen and section chiefs at 110 major hospitals and comprehensive cancer centers nationwide. He has written on head and neck cancer and is affiliated with Ingalls Memorial Hospital in Harvey and Rush-Presbyterian-St. Luke's Medical Center, Chicago.

Manus C. Kraff, MD, of Chicago, is listed in the recently published *Best Doctors in America*, a referral guide to doctors in more than 350 medical specialties. A professor of clinical ophthalmology at Northwestern University, Dr. Kraff is also the founder of the Kraff Eye Institute in Chicago. The directory is compiled from results of a survey of doctors across the country who were asked: "If a friend or loved one came to you with a medical problem in your field of expertise, and for some reason you could not handle the case, to whom would you send them?" Of 17,000 board-certified ophthalmologists in the United States, Dr. Kraff is among 33 nationally, and the only Chicago-area cataract surgeon, identified in the directory.

A. Jerald Rothenberg, MD, of Evanston, was recently appointed president of the medical staff at St. Francis Hospital in Evanston. Dr. Rothenberg, a specialist in cardiology and internal medicine, completed a cardiology fellowship at Rush-Presbyterian-St. Luke's Medical Center in Chicago. Dr. Rothenberg has been a member of the St. Francis medical staff since 1969 and is a member of the American College of Physicians.

William N. Werner, MD, of Skokie, has been elected to a fellowship in the American College of Physicians. A board-certified specialist in internal medicine, Dr. Werner is with Illinois Masonic Medical Center in Chicago, where he is director of quality management and an attending physician in the department of medicine.

Fellowship in ACP is an honorary designation that recognizes scholarly and professional achievements in internal medicine. Dr. Werner will be recognized in a special ceremony during ACP's annual scientific session in April.



Little Company of Mary Hospital and Health Care Centers in Evergreen Park announced the appointment of **Kent F. Armbruster, MD**, of Westmont, as its new medical director. Dr. Armbruster is a diplomate of the American Boards of Internal Medicine and Nephrology, as well as an instructor at the Rush Medical School. He has co-authored many articles concerning nephrology in numerous medical journals.

A member of Little Company of Mary's medical staff since 1977, Dr. Armbruster has also served as chairman of the department of medicine, president and vice president of the medical staff and, most recently, a member of the hospital's Board of Directors.

Eugene R. Kovalsky, MD, of Winnetka, was recently elected president of the medical staff at St. Elizabeth's Hospital in Chicago. A radiologist, Dr. Kovalsky has been a member of the hospital's medical staff since 1986. He replaces outgoing medical staff president, Raquel Alvarez, MD. He will serve a one-year term.

Irving Frank, MD, of Sycamore, founder of Kishwaukee Medical Associates, has retired after 54 years in medicine. He was honored Feb. 21 at a reception at KMA, to which the entire community was invited.

Before settling in Sycamore, Dr. Frank was one of only two doctors attending 65,000 Navaho Indians on an Arizona reservation. He later obtained a PhD in psychology and offered his patients psychological counseling as well as primary care. Dr. Frank performed surgery, treated everything from sore throats to cancer, and delivered babies, including the first set of triplets in DeKalb County. Dr. Frank's wife, Roseanne, a nurse and NIU emeritus professor of nursing, describes him as "a modest man who made his piece of the world a little better place than it was." ■

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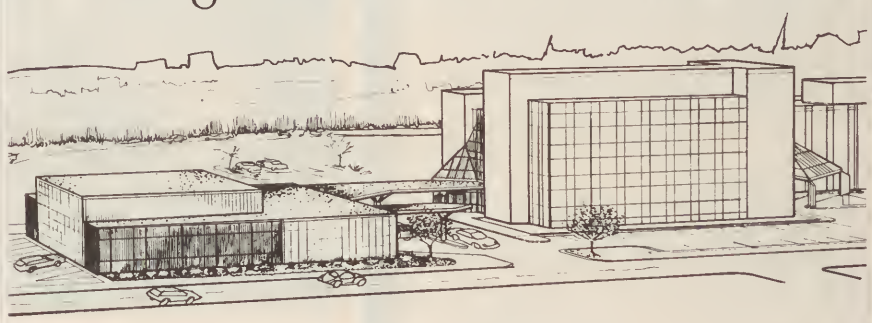
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ISMS BOARD BRIEFS

The Illinois State Medical Society Board of Trustees met Jan. 30 at the ISMS Conference Complex. The following are highlights of the board's actions:

Dues remain level

For the 1994 membership year, ISMS members will pay the same dues amount that they have paid since 1988. The board will make its recommendation to the ISMS House of Delegates in April.

Chodash supported for AMA council

ISMS will support the candidacy of Howard Chodash, MD, a Chicago resident physician member, for re-election to the AMA Council on Medical Education in June 1993.

IDPR application assistance requested

ISMS agreed to ask the Illinois Department of Professional Regulation to process temporary licenses more efficiently through the development of an internal tracking system and the addition of a field staff. ISMS is asking the department to seek creative solutions so that problem or deficient applications can be more speedily addressed.

Teen health brochure to be updated

The Society will expand and update its brochure about AIDS for teens to include information on adolescent depression and teen suicide; substance abuse, including alcohol, drugs and steroids; teen sexuality, including AIDS, STDs and teen pregnancy; tobacco and smokeless tobacco abuse; domestic and family violence; seat belts; eating disorders and nutrition; and peer pressure and self-esteem.

The current brochure "Facts for Teens (and their parents) about AIDS" is used by physicians who speak to teens in junior high and high schools.

ISMS maps legislative plan

ISMS is preparing its legislative options for 1993 by mounting support for tort reform legislation and health care reform proposals supported by the ISMS House of Delegates. The Society will seek to build a consensus for legislation with businesses, insurance companies and hospitals, as well as others interested in improving the liability climate. ISMS will also continue its aggressive Washington Presence program, especially in light of a newly elected president and many new faces in Congress. A special committee of the Board of Trustees will continue to review state and federal health care reform plans.

ISMS earns ACCME recognition

ISMS has received four more years of continued recognition as an accreditor of intrastate CME programs from the Accreditation Council on Continuing Medical Education's Committee on Review and Recognition. ISMS was commended for its well-defined procedure and surveyor manuals and its written policies and procedures.

Auxiliary recommends name change, sponsors interns

The Illinois State Medical Society Auxiliary will be the Illinois State Medical Society Alliance if its House of Delegates agrees with the Auxiliary board recommendation at the Annual Meeting. The new name will be accompanied by the tagline "Physicians' spouses dedicated to the health of Illinois."

To help people outside the profession understand medical practice, the Auxiliary and ISMS co-sponsor the mini-internship program, matching a community leader with a physician for a day. Eleven county medical society auxiliaries are hosting more than 50 interns. ■

Governors

(Continued from page 8)

"streamline the Medicaid waiver process." Under Clinton's instruction, the federal government will have only one opportunity to request additional information or clarification about state waivers.

"For years the nation's governors have been arguing that the process through which waivers from the Medicaid mandates imposed on them by the federal government is byzantine and counterproductive," Clinton said during his Feb. 1 address to the NGA. "They are right."

Clinton also told the governors he wants the U.S. Health Care Financing Administration to reopen negotiations with NGA to forge an agreement detailing how states can use provider assessment programs. Sullivan said Illinois is "hoping to get some quick answers" about whether the state will have to change its current provider assessment program. "We're assuming [the regulations governing assessment programs] will be more relaxed, less burdensome," she said. "We will really be pushing to get definitive answers before our current program expires [June 30]."

Clinton also asked NGA leadership to provide direct input to the National Health Care Task Force to combat the "twin monsters" of spiraling costs and limited access. Four key governors will be part of Clinton's national task force including Howard Dean, MD, of Vermont, the only physician-governor in the nation. ■

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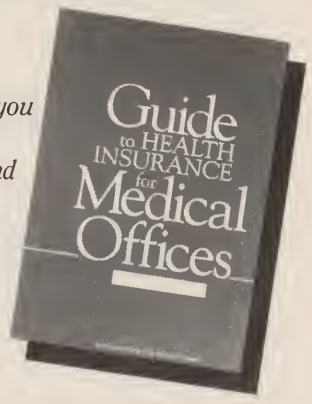
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HCFA halts lab's cytology operation

(Continued from page 1)

results, said Charles Bennett, U.S. Health Care Financing Administration branch manager for program review. "We were able to confirm [their concerns] I regret to say," Bennett said. "The number of errors we found was serious enough that we believe it posed a serious and immediate threat to [the lab's] clients."

A review of 500 to 600 cytology slides evaluated at Stroink labs from 1990 to 1992 was performed last month by cytotechnologists and a consultant pathologist from the American Society for Cytotechnology. Of those 500-plus slides, 70 to 80 merited further review by a pathologist. The physician determined that more than 50 slides in the test group had been read improperly and were assigned inaccurate diagnoses, Bennett said. This includes false negatives and false positives.

DURING THE PAST TWO YEARS, Stroink has processed an average of 100,000 Pap smears annually, Bennett said. Under the federal laws governing laboratory operation, Stroink was obligated to tell the HCFA regulators who its "clients" are, and the lab complied, he noted. Subsequently, those 46 Illinois clients – including individual physician offices and group practices and clinics – have received letters from IDPH detailing the lab sanctions.

The IDPH letter also states that the consultant pathologist noted a "number of diagnostic discrepancies in the laboratory's reports of patient results." Because of the "number and significance" of the inaccurate readings HCFA identified, the letter suggests to physicians that test results received from Stroink during the past two years "may not represent an accurate diagnosis of your patient's condition."

At the same time, the Illinois State Medical Society sent letters outlining the government's action to downstate county medical society presidents covering a 37-county area. In the Feb. 9 letter, ISMS Board Chairman Jere E. Freidheim, MD, said the Society is encouraging doctors who may have sent patient tests to Stroink between 1990 and 1992 to notify all patients whose test results may be affected and assist in retesting patients' specimens when appropriate. The CLIA regulations do not mandate that the sanctioned laboratory notify patients.

"ISMS is concerned that patients should be made aware of potential inaccuracies in their cytology test results," Dr. Freidheim wrote. "ISMS is further concerned that the medical decision making of physicians be undertaken based upon reliable test results. ISMS encourages physicians to discuss with affected patients whether retesting of previously collected specimens or new testing (or both) is indicated."

DECISIONS ABOUT RETESTING should be made by physicians in concert with their patients, said IDPH Director John R. Lumpkin, MD. "We believe an orderly notification [of patients] should be undertaken by the health care provider. This will allow the physician-patient relationship to be maintained, and [together] they can best determine what appropriate action to take."

HCFA's Bennett said Stroink is under orders not to perform any cytology testing until an acceptable plan of corrective action is submitted. In the meantime, Stroink is permitted to continue lab testing in all other areas except cytology, since the HCFA investigation was limited to only those cytology tests, he said.

"But the bottom line is that the facility is working on correcting the problems," Bennett said, adding that HCFA will probably survey other areas of Stroink's laboratory testing facility. "We have the right and the obligation to do a full survey of their entire lab. It's up to them now to convince us that they are in full compliance with the federal standards."

Jim Finegan, the Bloomington attorney representing Stroink Labs, confirmed in published news reports that the lab is currently working on an acceptable corrective action plan. Finegan also noted in news coverage that the lab will not appeal HCFA's action stopping cytology testing at Stroink. Repeated attempts by *Illinois Medicine* to reach Finegan were unsuccessful.

Bennett said Stroink is not the only laboratory in the region currently under investigation. Although no other Illinois labs have been found out of compliance to date, several Michigan laboratory operations were recently found noncompliant and are operating under on-site HCFA monitoring. HCFA also recently completed a survey of Illinois' public health labs in Springfield, Carbondale and Chicago; all meet the federal CLIA standards, Bennett said.

"The purpose of this [CLIA] legislation is to assure the public that safe lab testing is going on," he said. "We will take a tough position and use all of the sanctions at our disposal to assure that the lab is in compliance and stays in compliance." ■

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Physician speakers

(Continued from page 1)

T. Mitchell, MD, co-chairman of the ISMS Committee on Health Care Access. "The intent is to work with local doctors and county medical societies, as well as the community. Getting doctors together is the whole concept."

Also available free of charge to community groups is "Rural Health: Reaping the Benefits of Community Action," a kit developed by ISMS as a resource for groups attempting to bring quality health care to their communities. Included in the kit are names and addresses of physician recruitment resources, state and federal funding sources, medical schools and foundations. The pamphlet "Producing Solutions Through Effective Organizing," also included in the kit, offers detailed suggestions for defining the health care problem, working together, and seeking the support of established physicians, as well as recruiting new ones.

THE MOST DIFFICULT STEP for any community is getting started. The speakers bureau will help communities get over the hump, identify sources of help and teach communities how to initiate a long-term plan that evaluates all the solutions and their costs.

More specifically, speakers will address the issues involved in physician recruitment, such as making the community appeal to a prospective recruit, reducing the physician's sense of professional isolation and planning financial incentives. The program also emphasizes encouraging young men and women to consider careers in health care. Local physicians can be strong role models in encouraging youths to return to the community after medical school. But the speakers will mostly stress the need for communities to do the work themselves by including as many people and groups as possible and without relying heavily on outsiders.

To schedule rural health speakers, groups may contact the ISMS Health Care Finance Division at (312) 782-1654 or (800) 782-ISMS. Speaking engagements will be scheduled only with the concurrence of the county medical society. ■

Vaccine program

(Continued from page 5)

in a timely fashion and in a manner that is easy and comfortable for both patients and providers," said Terry F. Hatch, MD, a pediatrician from Urbana. While he supports the idea of the national program, he echoed the concerns of others regarding its effect on R & D. "We can expect the [pharmaceutical] industry to contribute to the whole arena, but we shouldn't expect them to bear the brunt of the expense."

During the first 20 years after the discovery of the measles vaccine, public health experts estimate that more than $5 billion was saved in medical costs. The AAP estimates that every dollar spent on immunizations saves $10 in future health care costs.

Dr. Hatch stressed the urgency of a national program: "To date the regional and local programs are simply not successful. We can't accept anything less than universal access and delivery for all childhood immunizations." ■

Belleville smoking suit

(Continued from page 1)

responsible for his own actions and should have heeded warning labels. Kueper began smoking at 14 and averaged 1½ packs a day until he quit after his lung cancer was diagnosed.

"There's still a chance for plaintiffs in these cases," said Bruce Cook, Kueper's lawyer. He said the problem lies in the jury selection, since "people who think [everyone knows] smoking causes cancer can't be fair because they've already made up their minds." Cook has recently been in the news as the plaintiff's attorney in the *Roth vs. Vest* case, in which James V. Vest, MD, and his lawyers were jailed when Dr. Vest refused to answer one of Cook's questions during a deposition.

"It was a tough case," Cook said. "The tobacco companies spend millions to hoodwink juries and the public. The plaintiff is a good man. He feels he was encouraged to smoke as a kid and that tobacco companies still encourage kids to smoke. It should be stopped.

"He's going to die," Cook continued, speaking of Kueper. "He [filed the suit] only for the public good."

The verdict in the Kueper case is similar to previous verdicts in that personal responsibility was the most compelling issue, said Maura Payne, spokesperson for Winston-Salem, N.C.-based R.J. Reynolds. She explained that Kueper had chosen to continue smoking even after 25 years of warnings from the company. "The jury did a good job," she said. "They gave a detailed analysis of the evidence."

Nevertheless, Payne said the verdict probably won't curtail similar suits. "There have been 300 suits like this in the past 30 years," she said. The common thread is that the plaintiffs had read the warnings and continued to smoke.

> *This does not absolve the tobacco industry from taking some responsibility, but you can't award damages when the plaintiff could have taken responsibility for his own health.*
>
> **RONALD G. WELCH, MD**

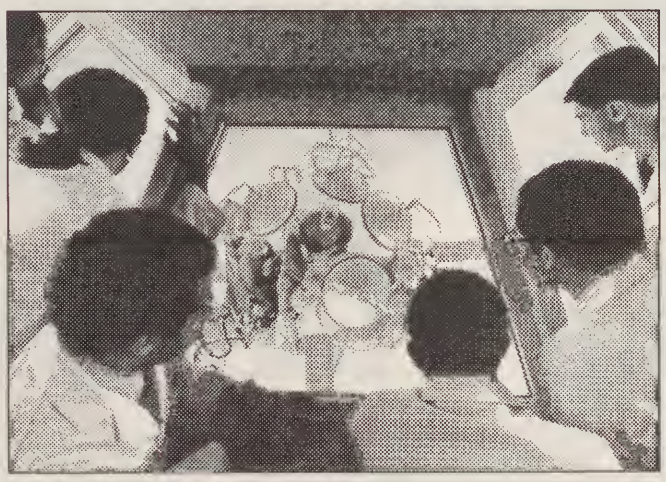
The difference in the Kueper case was the conspiracy charge, which Payne said was unusual but had also been filed in the Supreme Court case. The suit, which was filed on behalf of Rose Cipollone, who died of lung cancer, was dropped by the plaintiffs in November 1992 following 10 years of litigation. Cipollone's family had been awarded $400,000 in 1988 – the first award against a tobacco company – but the decision was overturned on appeal. The court ruled in June 1992 that warning labels will no longer protect manufacturers from damages, and the decision returned the case for retrial, but the plaintiffs dropped the suit instead.

"I CANNOT THINK of a physician or anyone else who thinks tobacco is good for anyone," said Ronald G. Welch, MD, Illinois State Medical Society Tenth District trustee. "It's a well-known hazard. On the other hand, people have a responsibility to take care of themselves."

Dr. Welch described the Kueper case as unusual because juries are "notorious for handing down plaintiff decisions." During the trial, Cook had asked for damages to be awarded even if the jury found Kueper responsible for his own health, Dr. Welch said. The judge agreed, but the jury awarded no damages despite the advice.

"If any damages were awarded, the public would ultimately suffer," Dr. Welch continued, saying that such a finding would set a poor precedent, akin to making the candy maker responsible for cavities in children's teeth. "This does not absolve the tobacco industry from taking some responsibility, but you can't award damages when the plaintiff could have taken responsibility for his own health." ■

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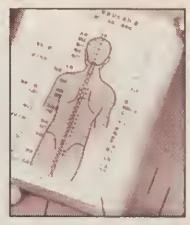
AL REASON YOUR PATIENT SEEKS CARE (PAGE 9)

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MARCH 12 1993

State disciplinary process rooted in fairness

PAGE 3



Alternative medicine: Toward the unconventional

PAGE 12



JAY BARNARD, SENATE REPUBLICAN STAFF

Sen. James "Pate" Philip

Philip eyes tort reform

GOP CONTROL: The Illinois Senate will now be directed by the Republicans. By Tamara Strom

[SPRINGFIELD] Claiming the news media have gone overboard in calling his ascension to Senate president a personal victory, Sen. James "Pate" Philip (R-Elmhurst) said what's more important is the effect the Republicans can have on public policy.

"As they like to do, [the media] focus on individuals and personalities," Philip explained. "But that's misleading. They talk about the change in leadership in the Senate as though the only thing that changes is who the Senate president is. The Senate president is

(Continued on page 18)

INSIDE

Scarcity of women in research hinders patient care, group says

PAGE 17



Computers: Taking the hassle out of health care

PAGE 5

Case in Point explores mammography

PAGE 10

DEPARTMENTS

News Briefs.....2
Illinois Watch 4
Commentary...6, 7
ISMIE Update 9
Classifieds 15

ISMS goes to Washington

WASHINGTON PRESENCE: Illinois physicians met with the new administration and members of Illinois' congressional delegation. By Tamara Strom

[WASHINGTON] The physician leadership of the Illinois State Medical Society traveled to the nation's capital Feb. 24-25 to meet with some of the key players working on health care reform. After two days of meetings and briefings, the jury's still out.

The ISMS representatives met with Clinton administration health care reform liaisons and several newly elected Illinois congressmen. Some information about the direction of the reform process was culled, but the physicians learned few specifics. Most new congressional representatives said they have an open mind about reform and are not yet ready to endorse one type of plan over another.

The Society's physician delegation included ISMS Board Chairman Jere E. Freidheim, MD; President Arvind K. Goyal, MD; President-elect Arthur R. Traugott, MD; Exchange Board of Governors Chairman Harold L. Jensen, MD; and trustees William E. Kobler, MD; Alan M. Roman, MD; John F. Schneider, MD; and M. LeRoy Sprang, MD.

A Feb. 24 joint dinner with the Illinois congressional delegation and ISMS leadership featured a presentation on the progress of health care reform by Judith Feder, prinicpal deputy assistant secretary for planning and evaluation at the U.S. Department of Health and Human Services. Feder also is a member of the President's Health Care Reform Task Force.



DAVID HATHCOX

ISMS leaders gather in front of the White House following their meeting with a representative of the president's task force on health care reform.

The ISMS physicians met at the White House Feb. 25 with members of Clinton's health care reform team and officials from the Office of Management and Budget.

During face-to-face meetings on Capitol Hill, the doctors talked with Illinois' freshmen U.S. representatives about tort reform and other physician concerns. The doctors met with Rep. Bobby Rush (D-Chicago); Rep. Luis Gutierrez (D-Chicago) and Rep. Donald Manzullo (D-Rockford).

The ISMS leaders exchanged ideas with veteran representatives John Porter (R-Wilmette);

(Continued on page 17)



Edgar's '94 budget plan

Illinois children are the big winners in Gov. Jim Edgar's proposed fiscal 1994 budget announced March 3. "When it comes to a choice between kids and concrete, the kids must win," Edgar said.

Among Edgar's proposed measures are:

- Retaining $211 million in surcharge funds earmarked for local governments so that Illinois doesn't duck timely payment of medical bills to providers treating state employees;
- Increased funding for the state's AIDS program and mental health services;
- Acknowledging action is necessary this session, Edgar withheld a specific Medicaid assessment plan until promised relaxations of matching fund rules are announced. ■

ISMS BEHIND THE SCENES

MINI-INTERNSHIPS BENEFIT PHYSICIANS AS WELL AS INTERNS

As the nation moves closer to reforming the health care system, the Illinois State Medical Society and the Illinois State Medical Society Auxiliary sponsor the mini-internship program to help educate local policymakers and shape the public's opinion of medicine.

The mini-internship program gives nonmedical professionals the opportunity to observe firsthand the practice of medicine and the daily obstacles physicians encounter. Local, state and federal government officials, business and community leaders, and media representatives exchange their business attire for medical gear and accompany a physician for a day.

When the program was launched in 1991, six counties offered it, hosting 25 interns. As the program's importance grew, so did its popularity with physicians and interns alike. This year, more than 50 interns participated in mini-internships offered by 11 medical societies, including those in Kankakee, Livingston,

(Continued on page 18)

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Bill introduced to combat health care fraud

NEW COMMISSION: An Illinois lawmaker proposes federal legislation aimed at cutting fraud's annual $80-billion price tag. By Tamara Strom

[WASHINGTON] Contending that the battle against fraud is an integral piece of the health care reform pie, U.S. Rep. Richard J. Durbin (D-Springfield) introduced legislation last month to stem fraud and abuse. In announcing the bill, Durbin cited General Accounting Office statistics showing fraudulent billing and cost shifting will cost the country $80 billion this year.

"Health care fraud is a serious problem that costs Americans billions of dollars through increased medical bills," Durbin said. "The only way to tackle the problem is to establish a coordinated national commission to fight health care fraud and abuse."

H.R. 671, or the Ted Weiss Memorial Health Care Fraud and Abuse Commission Act of 1993, would set up a national panel of experts to chart strategies for ending fraud. The bill, which mirrors legislation introduced last year by the late Rep. Weiss of New York, calls for the commission to coordinate "public and private prevention, detection and enforcement efforts," Durbin said.



Rep. Richard J. Durbin

The commission would comprise representatives from the "relevant federal agencies, state investigative and prosecutorial agencies and private players," he noted. According to the American Medical Association, the commission would include physician representation. But while the AMA supported Weiss' bill last session, the association is awaiting more details before endorsing Durbin's proposal.

In fact, few physicians are involved in health care fraud, "because fraud activity is contrary to the service reason why most physicians choose medicine as their career," said Arvind K. Goyal, MD, Illinois State Medical Society president. "Even one case of fraud is too many, and the ISMS supports attempts to eliminate fraud and abuse."

The GAO report said health care fraud accounts for about 10 percent of the nation's overall health spending, including a $32-billion annual cost to the federal government. In crafting his bill, Durbin incorporated the following GAO points, which the agency said make the system "vulnerable" to fraud:

- The "massive" number of claims processed conceals some fraud.
- Confidentiality concerns hinder insurers in comparing possible fraudulent billing patterns, such as claims submitted for more than 24 hours of care in a single day.
- Costly legal and administrative fees often deter third-party payers and the government from prosecuting.
- Although unscrupulous distributors and providers may be detected and stopped from bilking the system at one level, such as Medicare, they may continue their fraudulent schemes at another rung of the reimbursement system, like private insurance. ■

ISMS blasts government-run health care proposal

[CHICAGO] While reiterating its support for universal access to health care, the Illinois State Medical Society March 3 questioned a legislative proposal pushed by the Campaign for Better Health Care. The plan advocates a government-run health care system funded with huge tax increases. ISMS President Arvind K. Goyal, MD, called single-payer systems a "prescription for disaster.

"President Clinton has been advised that a government-run health care system would be cost-prohibitive under his budget deficit plans and would not actually deliver universal access to care," added Dr. Goyal. "It appears this new push for such a drastic proposal is nothing more than a frantic response to the president's movement away from universal health care."

Dr. Goyal said ISMS endorses health care reform that maintains the strengths of the current system, such as the world's highest-quality care. To achieve such reform, the public-private mix of health care financing and delivery systems must be preserved. In addition, the system must include "carefully constructed cost-containment efforts," he said.

Such efforts include much-needed tort reform, such as malpractice caps, Dr. Goyal noted. "Genuine health care reform must include malpractice reform. Health care costs cannot be effectively controlled until we eliminate all waste, including huge lottery-type noneconomic awards paid to a few at the expense of everybody else," he said.

Other ISMS-supported reform measures include adequate funding of Medicare and Medicaid to expand access to all eligible recipients and ensure the programs' long-term financial stability. Health insurance industry reforms also must be part of the mix, making coverage available – and affordable – to all citizens despite their employment or health status. Eliminating pre-existing condition limitations and invoking community risk rating also are required, Dr. Goyal said. ■

Resident seminar held

[CHICAGO] A seminar conducted Feb. 13 at the Illinois State Medical Society headquarters helped resident physicians prepare for their future in practice. The seminar was co-sponsored by the ISMS Resident Physicians Section and the American Medical Association.

To kick off the meeting, ISMS-RPS Chairman Mark Bair, MD, urged residents to participate in organized medicine through the section. Then, Robert Hecht, instructor, from the AMA Financing and Practice Services Inc., discussed the pros and cons of solo vs. group practice. The morning session ended with an analysis of valuing a practice.

The afternoon segment began with a program on evaluating a professional liability insurance policy, presented by Alan M. Roman, MD, president of the Chicago Medical Society and a member of the Illinois State Medical Inter-Insurance Exchange Board of Governors.

A follow-up on contract negotiation by Judee Gallagher, an attorney practicing in Chicago. ■

Tennis event criticized

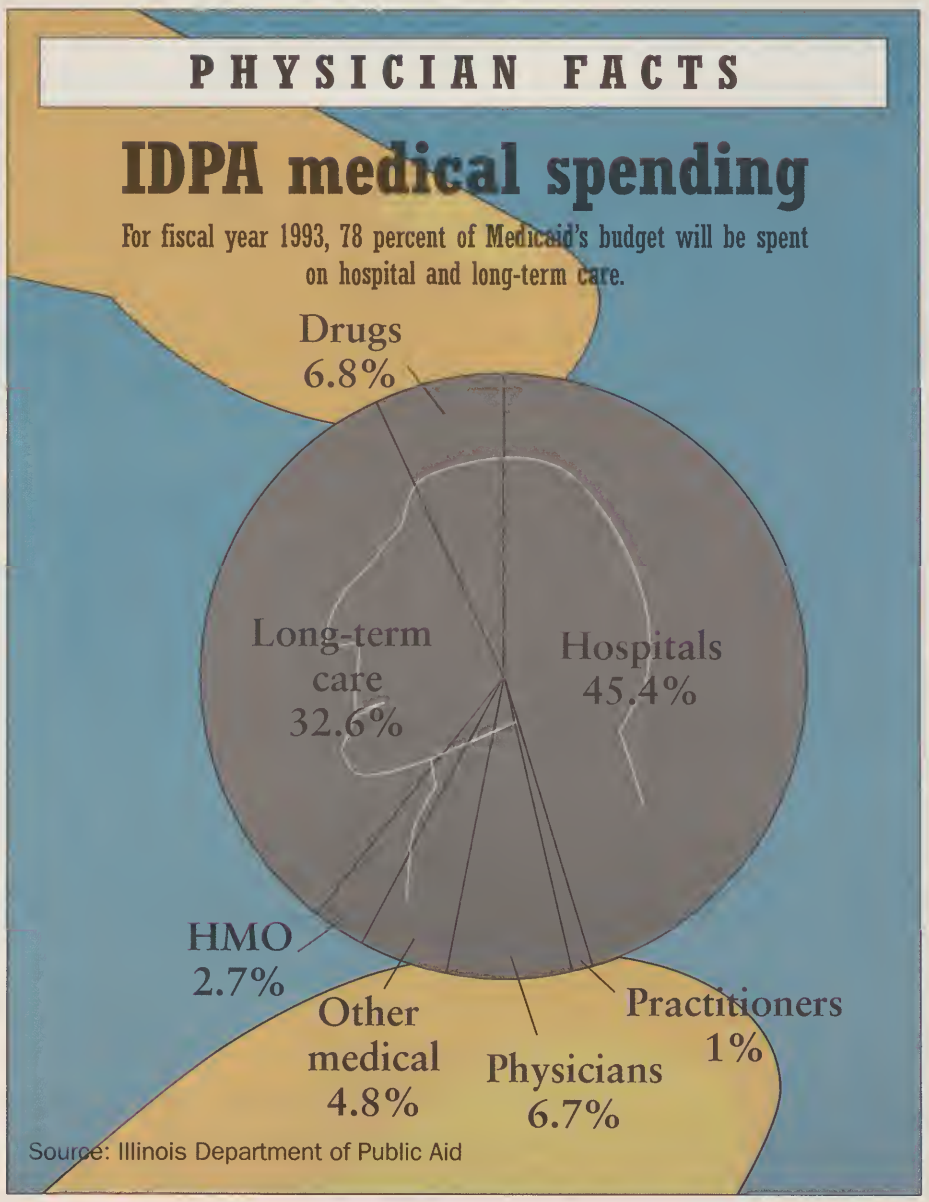
[CHICAGO] Long after everyone forgets the good tennis in the finals of the Virginia Slims Women's Tennis Tournament Feb. 14, Chicago-area physicians will continue their outrage about the tobacco company's participation. To make matters worse, the doctors said, the tournament was held at the University of Illinois at Chicago's Pavilion.

"Anything that would tend to give the perception of support for a tobacco-supported event [at the university] is improper," said Melvin Lopata, MD, who practices pulmonary medicine at UIC.

Because UIC is a major medical research school, "some people on campus see [the university's role as] a contradiction," said a university spokesperson.

The Virginia Slims slogan "You've come a long way, baby" is "probably the only truth in tobacco advertising in years," Dr. Lopata said, noting the "progress" of women in contracting smoking-related diseases.

The university is currently reviewing its hosting of the tournament, and a decision will be made soon, according to UIC. ■



CLARIFICATION

In the Jan. 29 issue of *Illinois Medicine*, the guest editorial "Unlimited care for some or basic care for all?" by Biswamay Ray, MD, stated that the Oregon health care proposal advocated providing basic care for all state residents. The sentence should have stated that the plan advocated basic care for state residents ineligible for Medicaid coverage. ■

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State disciplinary process rooted in fairness

DELICATE BALANCE: The Illinois State Medical Disciplinary Board walks the fine line of ensuring public safety and due process for physicians. By Tamara Strom

[CHICAGO] When allegations of sexual misconduct were leveled against an Illinois physician earlier this year, the media turned its spotlight on the event, showcasing the public's outrage that a doctor might abuse the trust of his or her patients. What the headlines and newscasts fail to explain, however, is that instances such as these are few in number and that truly negligent or unethical physicians do not go undisciplined in Illinois. The Illinois State Medical Disciplinary Board sees to that.

Illinois' disciplinary process is "fair, but tough," said Biswamay Ray, MD, disciplinary board chairman and a Third District trustee of the Illinois State Medical Society. One strength of the process is that the board "not only protects the citizens of Illinois, but tries to give every physician due process," Dr. Ray said. "The board never tries to railroad anyone; [all] physicians should be given due process as is their right under the law. But due process does not mean protection for physicians who are giving substandard care. There are only a few bad apples, or bad physicians. The public can feel secure that the vast majority of doctors are honest, decent, and competent, and practice good medicine."

> *Physicians should be given due process as is their right under the law. But due process does not mean protection for physicians who are giving substandard care.*
>
> **BISWAMAY RAY, MD**

Dr. Ray said that although the board is committed to ensuring due process, it does not "bend over backward" to protect physicians. The nine-member board – composed of five MDs, one doctor of osteopathy, one chiropractor and two nonvoting lay members – takes "tough disciplinary action" when warranted. Physicians can be disciplined for any violation of the Medical Practice Act, from not renewing a license within the 90-day grace period to gross negligence or criminal misconduct. The practice act is a clear standard against which all allegations are measured, he said.

"Our main objective is to protect the public," Dr. Ray said. "But we are also protecting the medical profession from incompetent, impaired or unethical physicians."

WHEN HIGH-PROFILE CASES are "put on trial" in the media, the board simply ignores the press coverage, Dr. Ray explained, adding that for the disciplinary process to work, each case must stand on its own merits. The board members "have seen this kind of media attention before, and it has no effect on them. We have no control on the media and how they publicize any particular case, but the publicity will have nothing to do with the board's review of the case or have any effect on any final action taken."

The Illinois Department of Professional Regulation underscored the fairness of the board's actions. "It's a great board," said Nikki Zollar, IDPR director. "They are very dedicated members, people who really give a lot to the process even at the expense of their practices at times."

The board members are impartial and have a good understanding of the law, IDPR said. The board looks at each case objectively and evaluates whether the department has proved its case, according to the department. In addition, the board members work well together and form a cohesive body that knows what the standard disciplines are and what is appropriate in a given case, IDPR added.



Biswamay Ray, MD

The disciplinary process in Illinois, as spelled out by the Medical Practice Act, is stronger than in other states, board

(Continued on page 19)

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REPORT FOR *Illinois Physicians*

TO ILLINOIS PHYSICIANS:

We would like to take this opportunity to inform you about the Medicare Part B Carrier Advisory Committee of Illinois.

For some time now, the Health Care Financing Administration (HCFA) has been concerned about physician complaints that Medicare's administrative requirements compete with the time available for direct patient care and increase the overhead cost of practice. As a result of these concerns, HCFA formed a national Advisory Committee on Medicare-Physician Relationships. One of the recommendations of this committee was that each Medicare carrier establish a Carrier Advisory Committee which would focus on improving these relationships.

The purpose of the Illinois Carrier Advisory Committee is to provide a:

- means for physicians to be informed of, and participate in, the development of local medical review policy.
- mechanism to identify areas which need improvement in the administration of the Medicare program and to achieve resolution of these identified problems.
- forum for exchange of information between the physician community and Medicare.

The membership of this committee consists of representatives of state and specialty physician societies; peer review, medical management and state hospital associations; and a beneficiary group. Each society designated one of its members to participate on the committee. Some of the functions of this committee are to:

- distribute draft medical policies to colleagues for review and input to insure that the policies reflect the standard of practice in Illinois.
- disseminate information about Medicare issues obtained at the meetings to respective state and specialty societies.
- advise the Medicare carrier about issues, administrative problems, inconsistent or conflicting medical review policies and new technologies, so that these subjects can be addressed in a timely fashion.

Two meetings of the committee have been held to date: October 19, 1992 and January 28, 1993. Meetings occur on a quarterly basis and we anticipate the third meeting will be held in April.

Questions concerning this committee should be directed to Douglas Busby, M.D., Medicare Medical Director, at (312) 938-7931.

(Issue: 03/12/93 - MedB)

Quincy to have one hospital after all

BUYOUT: After a failed merger and weeks of negotiations, officials announce the sale of St. Mary Hospital to Blessing Hospital in Quincy. By Gina Kimmey

[QUINCY] "From the beginning, our intention has been to assure the people of Quincy the best possible care," said Sister Marilyn Fischer, chairman of the Franciscan Sisters of the Poor Health System Inc., the parent corporation of St. Mary Hospital. That intention gave birth to the idea of "Providence Hospital" – a proposed merger of St. Mary's and Blessing hospitals that failed in December after disagreements over administrative control. On Feb. 16, officials from the FSPHS and Blessing Hospital announced a buyout of St. Mary's by Blessing. "Failing to achieve the goal of a single hospital because of an impasse over the mechanisms for achieving it was not acceptable, and neither Blessing, St. Mary, our system nor the community would have benefited," said Sister Fischer.

The decision to have one hospital in Quincy resulted from studies conducted in 1992 that identified several benefits of such an action. A single hospital would eliminate wasting money on duplicate services and competition, as well as create opportunities for higher-quality and expanded facilities. Speaking for Blessing, Board Chairman David Ayers said, "We believe this action represents the right move at the right time for the right reason on behalf of high-quality, affordable health care for people of the Quincy region. We know this decision by the Sisters to withdraw their sponsorship from Quincy has been a difficult and painful one, and we laud them for their courage."

The Adams County Medical Society is pleased that Quincy will be served by one hospital. "What we are hoping is that [having one hospital] will improve quality," said Steven Ginos, MD, president of the Adams County Medical Society. "The hospital won't be wasting money competing with the guy down the street, which has proved counterproductive." He said the county medical society would like to see increased physician input and has asked Blessing for more physician representation on the board.

A Quincy family physician, Dr. Ginos said he thinks having just one hospital will greatly benefit the area, but the transition may be difficult for some members of the community. "It would have been easier on the public psyche if it had been 'Providence Hospital' – a totally new hospital – not one or the other," said Dr. Ginos.

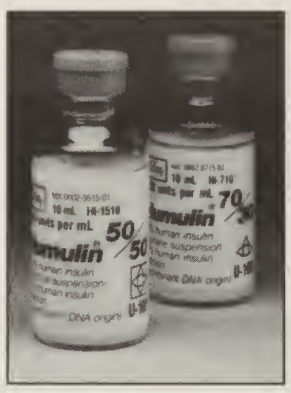
A sale agreement was reached Feb. 12 by representatives of the two not-for-profit organizations, and pending approval by government regulatory agencies, will take effect about March 31. Services at St. Mary and Blessing will not be affected prior to closing of the sale, and at closing all St. Mary employees will become employees of Blessing. With the details and negotiations over, Ayers said, "We look forward now to building for the future." ■



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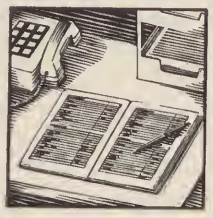
In addition, **ISMS President Arvind K. Goyal, MD, is available for membership** calls the first Wednesday of every month, 11 a.m. to noon. Use the toll-free or Chicago number above and ask for extension 1333. ■

Computers: Taking the hassle out of health care

By Rachel Brown

Imagine being able to access a patient's medical record in seconds. Imagine a physician's office devoid of cumbersome records and files. Imagine just touching a button to submit insurance and Medicare claims, check claim status or find out a patient's eligibility for treatment.

Sound too good to be true? Not for the hundreds and possibly thousands of physicians who are taking the hassle out of health care by combining the technology of computers with the science of medicine.



While many physicians are still wrestling with the idea of computerization, Pekin internist Ruth Kopp, MD, has spent the past two years perfecting a system that has saved her both time and money.

"In my solo practice, the computer is saving me the salary of 1½ persons because it does all the billing, filing, prescriptions and correspondence, and it catches errors," she said. "It has also freed up my time to practice more preventive medicine."

WITH A COMPUTER TERMINAL, keyboard and printer in each examining room, Dr. Kopp records all medical histories during examinations and can easily access details of the patient's last visit and treatments. Patients leave her office with a computer printout including everything from lab report results to prescribed medications and their instructions.

"[By giving the printouts], there is a lot less mystery as to what's going on and patients feel more comfortable that there aren't any secrets," said Dr. Kopp.

Dr. Kopp can also access a patient's medical record after office hours by using a terminal at home and without "having to rely on my memory for everything."

In addition, the computer gives her added protection for her records and receivables. "It would be impossible to cart around files on 1,000 patients, but my records are all contained on tapes, which I can carry with me," she said.

Chicago surgeon Antonio Ramos, MD, found that office computerization offered added security in handling payrolls, taxes, daily income, and insurance and Medicare billing. His practice, which serves 20,000 patients a year, was computerized last year after Dr. Ramos realized his accounting service and several employees were stealing. He now believes the $20,000 invested in the system is "peanuts" compared to the savings in time and money.

"The computer paid for itself after only three months and [has eliminated] the margin of error," he added.

SIX MONTHS AGO, Share Health Plan of Illinois, a Chicago-area HMO, began an electronic claims system to allow physicians to submit claims, check claims status, file referrals and determine a patient's treatment eligibility through its office computer, said Pam Postlewaite, office manager at Suburban Primary Care in Arlington Heights.

"I just love it," said Postlewaite, whose office was the first one connected to the system. "I would like to see every managed care group be able to receive everything electronically."

(Continued on page 14)



DUANE ZEHR

Pekin internist Ruth Kopp, MD, said by computerizing her office, she can spend more time teaching patients about preventive care.

Checklist for computer shoppers

Before installing or upgrading a computer system in your practice, take time to assess your needs and research various computer vendors and their products. The following tips, based on guidelines published in *Texas Medicine,* should help you analyze your practice's needs.

You probably need a computer if the following descriptions apply to your practice:

- You have a full-time employee who spends more than 50 percent of his or her time handling claim forms and billing.
- You spend at least $300 a month on an outside billing service.
- Your staff needs five or more days to complete and mail claims.
- Your turnaround time in receiving payments from claims is more than 15 days.
- You file a moderate to high volume of Medicare and/or Medicaid claims.

Tips on finding a computer vendor:

- Consider hiring an independent consultant, without financial ties to any specific hardware or software manufacturers, to evaluate your needs.
- Consult journals such as *M.D. Computing, Computing Physician* or *Physicians and Computers* to learn about the latest developments.
- Talk with your colleagues about their experiences with computer products and vendors.

What you should know about a vendor's products:

- Which functions (billing, electronic claims, word processing, etc.) are part of a basic package and which will cost extra;
- How user-friendly the product is, how much training is required and how much training the vendor will provide;
- Whether this product will fulfill your assessed needs;
- Which security features are available;
- What type of hardware is needed;
- What operating system (DOS, UNIX, etc.) is needed.

What you should look for in computer hardware:

- The manufacturer is reputable and offers an industry-standard warranty and/or an extended service contract on its products.
- It can expand as your needs change and it can be upgraded if a new product is developed.
- Its service contract specifies costs and terms, including whether qualified local service representatives are available on short notice. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

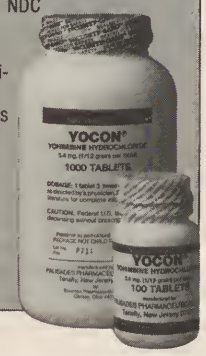
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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EDITORIAL

Patient beware

Consumers are getting a lot of information about physicians these days. The trouble is, it isn't always representative and sometimes isn't even accurate.

Magazines like *Good Housekeeping* and *Chicago* have published rankings of "top doctors." In the *Chicago* survey, head nurses and practicing doctors at 79 area hospitals were asked to recommend leading local physicians in 45 specialties and subspecialties.

A letter written by an MD and published in the March issue of *Chicago* outlined the primary problem with this approach – doctors aren't restaurants and shouldn't be rated as such. The job of interviewing doctors at every hospital in the Chicago area is formidable, couldn't be done and shouldn't have been attempted.

Private practice physicians and doctors at nonteaching institutions were "almost completely excluded" from the survey, stated a letter from President of the Chicago Medical Society Alan M. Roman, MD.

And ISMS President Arvind K. Goyal, MD, pointed out that by omitting family physicians from the list, the survey promoted superspecialists.

Newspapers such as *USA Today* picked up the January report by a self-styled consumer advocacy group, the Public Citizen's Health Research Group, regarding disciplinary actions by state medical boards. Public Citizen's director Sidney Wolfe, MD, is quoted in the *USA Today* story as saying, "People who live in states with better boards are protected from the kinds of doctors who are injuring or killing people in states with the worst boards." A response from James Winn of the Federation of State Medical Boards appears at the end of the piece: "[The report] plays a numbers game suggesting medical boards should be rationed by the number of scalps on the lodge pole." Winn said that with stricter licensure requirements, more doctors are denied licensure, so less action is necessary.

That opinion was seconded by Dr. Goyal, who attributed decreasing physician disciplines in the state to disciplinary process reforms enacted when the Medical Practice Act was amended: "IDPR tries to ensure that only those physicians with absolutely impeccable professional credentials get licensed in Illinois. Consequently, these physicians are less likely to need to be disciplined later."

Illinois State Medical Disciplinary Board Chairman Biswamay Ray, MD, refigured the Public Citizen's calculations for the number of serious actions per 1,000 MDs in 1991 and found that Illinois' rate was 4.6, not 2.7. So Illinois should have been in 22nd place in the overall state rankings, not 36th place – a significant difference.

The truth is that rankings should be interpreted for what they are – interesting reading, maybe, but not information to be taken literally. They just don't tell the whole story.

PRESIDENT'S LETTER

You can't cure it, but you can keep going

By Arvind K. Goyal, MD



Few patients, if any, come in with what the textbooks say are classical symptoms of a disease.

A young singer was flattered but completely winded when the discerning audience forced him to return and sing the same number for the fourth time. When "once more" was shouted a fifth time, he finally begged off, announcing it was physically impossible for him to go on. A voice boomed from the gallery, "You'll keep on repeating until you sing it right."

That is how I felt recently when a diagnosis of diabetes mellitus was established in yet another one of my teenage patients about to undergo tonsillectomy.

Having had a lot of diabetes in my extended family, my interest in this disease has been more than average. Few patients, if any, come in with what the textbooks say are classical symptoms of a disease. Polydipsia, polyphagia and polyuria are not the most common symptoms of diabetes in my practice. Unexplained weight loss, recurrent or persistent infections, routine chem screens, pre-surgical evaluations and routine screening tests in pregnancy frequently lead to the labeling of many diabetic patients these days.

Nothing is easy to the negligent, but diabetes is particularly tough on teenagers because of many restrictive covenants it brings with it. The need to eat right and regularly, the risk of hypoglycemia with unscheduled and erratic activities, the impact of emotional ups and downs, all make it a challenging affliction. And those daily injections and needles frequently raise the thought, "Why me?"

Years ago, I had done a first-grade physical on Maria when she was six. Other than a mild anemia, treated with iron, she was pronounced healthy. A few throat and ear infections later, she had physicals for fifth grade and then high school. A urine dipstix done at the time of each of those physicals did not show sugar. We talked about many things as she entered her freshman year – virtues and markers of good health and ways to stay clean in this dog-eat-dog world. She wasn't in any trouble then. That is until the beginning of her sophomore year!

Her mother brought her to my office one evening, with a history of nausea, vomiting and sudden onset pain in her right lower abdomen. A temperature of 100°F, rebound tenderness at McBurney's point, and a mildly elevated white cell count pointed to appendicitis. Results of her tests completed a few hours later and a surgical consultation in the hospital humbled me. What appeared to be a hot appendix settled down over the next day and a half without surgery and with aggressive treatment of her diabetic ketoacidosis and a urinary tract infection. She had none of those other diabetic symptoms, but a positive family history in an aunt and a grandparent. Diabetic education was well received – at least so it seemed! She impressed everybody including the dietitian. Her own Dextrostix results two days after her diagnosis matched the lab draws. She rejected an orange because she could handle learning insulin injections on herself. The fire had extinguished, but something underneath was smoldering indeed!

Maria did adjust to her new friend, diabetes, for a short while. She felt "stupid" after an insulin reaction following a Saturday night dance at school. Her grades slowly slipped. Her anxiety showed in many ways. She stayed out late some nights drinking with friends. Her father had found cigarettes and marijuana in her room. It is easier to fall sometimes than to get up and go!

Several hospitalizations followed over the next two years – some for uncontrolled diabetes mellitus associated with infections, others for noncompliance with diet and insulin. An endocrine consultation, psychiatric evaluations and several counseling sessions with a therapist, also attended by her family, did not change a thing. Visits by a home care nurse between her hospitalizations did not matter. Yet she managed to graduate from high school last year. She's now holding not one but two full-time jobs. She has no time to get sick again. What better reason to comply!

Maria is planning her marriage in the near future. Her prospective husband has asthma. He too had to learn to adjust to his illness during his school years. "If you can't breathe, you can't do much else," he told me when they both came to my office together recently for family planning and counseling purposes. They had heard that diabetes can act up during pregnancy and sometimes runs in families. They decided to use an effective contraception until they were ready for children. "It is never too late to learn," Maria told me. I am pleased I had not given up on her. And obviously learning has not stopped for me either!



"I'm invited to a seminar on 'not goofing up your practice with lousy management skills.' Hmmm, I wonder how they got my name."

GUEST EDITORIAL

Easing finances for residents

By Marc Duerden, MD

Despite financial hardship among residents, the federal government is seeking to impose a new student loan repayment system. Charles Darwin believed that natural selection occurs, and I believe that with the current changes in the repayment system, a financial selection of future doctors will occur: Unless they are rich enough to afford to pay medical school tuition and fees in cash, they may not be able to go to medical school.

The average medical student is $43,000 in debt by graduation, and the average indebtedness continues to increase. Previously, residents could defer loan repayment until after residency. American Medical Association policy still supports total student loan deferment throughout residency, but the federal government is in the process of again changing the repayment rules. In August 1992, President Bush signed a bill that threatened to eliminate deferment and limit forbearance (a grace period from loan repayment during which interest begins to accrue). A strong lobbying effort by the AMA and other groups including ISMS-RPS – coupled with a major grass-roots campaign – led to reinstitution of forbearance during residency and complete loan deferment for those residents who can prove need.

The current law allows residents two years of deferment and then, at the lender's discretion, forbearance until completion of the residency. After July, when the new law takes effect, there will be no automatic deferment, but there will be a possible three-year deferment for residents who can prove "economic hardship." The law further states that in defining economic hardship, the secretary of education must consider the borrower's "income" and "debt-to-income ratio" as primary factors.

One bright spot in this gloomy change is that residents – not lending institutions – will be able to decide whether they want to forbear their loans throughout their residency. This guarantees that residents will not have to make loan payments during residency, but it saddles them with a significantly larger debt at the completion of residency. All students who assumed loans prior to July will also have been grandfathered by the federal government into the current repayment system, not the less favorable one.

Residents nationwide obtained some of these favorable changes through their grass-roots efforts. Furthermore, the AMA attended the Department of Education regional meetings at which recommendations were made regarding the new law and DOE regulations. Last September, I attended a regional meeting at which suggestions were made regarding the terms for loan deferral.

Another important benefit of participation in the regional meetings was the opportunity to recommend an individual to work with the DOE in developing the new regulations. Recently the AMA learned that an AMA attorney will participate in the rule-making processes. Typically, organized medicine provides input when a bill is discussed or after regulations have been made.

This is one of many examples in which organized medicine has worked in a united effort to help physicians. It is incredible how many times I have heard the phrase, "I would join medical organizations, but they don't do anything for me." We do not realize how much our local, state and national organizations actually do to help us practice medicine. Furthermore, there are very few legislators who automatically advocate a physician's perspective when laws and regulations are developed; I am grateful for the work of organized medicine in this area.

Selection of the financially fittest in the next generation of physicians does not have to occur if we work together.

Marc Duerden, MD, is a senior resident specializing in physical medicine and rehabilitation at the Rehabilitation Institute of Chicago, Northwestern University.

GUEST EDITORIAL

Health care: a magic asterisk?

By Alan Murray

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Searching for huge spending cuts to tame a swelling deficit a dozen years ago, Ronald Reagan's ever-resourceful budget director, David Stockman, invented the "magic asterisk." It was a $44 billion line in the budget called "future savings to be identified." The savings were never identified, and the magic asterisk went down in history as one of the gimmicks that led to the nation's fiscal mess.

Today, President Clinton faces a similar dilemma. He has promised to cut $145 billion from the deficit in 1997, and his budget director, Leon Panetta, pledges two-thirds of those cuts will come from cuts in spending. But in the desperate search for savings, Mr. Clinton is also eyeing a magic asterisk of his own: health care reform.

Any health care reform worthy of the name must do two things: It must slow the spiraling of health-care costs, and it must begin to provide coverage to the 37 million people who are uninsured. The first saves the government money; the second costs money. Most health care analysts, including Mr. Clinton's, believe that in the next five years, the costs to the government will far outstrip the savings.

But there is one very important person who disagrees: the President of the United States. During the campaign, Mr. Clinton said repeatedly that getting health care costs under control is crucial to taming the deficit. And now that he has assumed the Oval Office, he has decided to act on his own rhetoric. Aides say he recently chastised health care advisers for telling him their plan can't be made to help reduce the deficit over the next five years.

Mr. Clinton was right to argue in the campaign that health care is a critical part of the long-term deficit problem. Expenditures on the Medicare program for the elderly and the Medicaid program for the poor are gobbling up federal dollars at an astounding rate, and could be the single biggest federal expenditure – bigger than defense or Social Security – by the end of the decade. Getting health-care inflation under control is thus critical to getting the deficit under control.

But in the short-term, any savings will quickly be gobbled up in the reform effort. "While fundamental health care reform is a crucial component of any long-run deficit reduction effort, it will not generate any savings over the next four or five years," says Robert Reischauer, director of the Congressional Budget Office.

Part of the problem, notes Mr. Reischauer, is that the federal government is already paying less than full cost for health care. Medicare, for instance, reimburses hospitals for only about 90 percent of the cost of caring for a Medicare patient, and Medicaid reimburses for only about 80 percent of costs. Patients with private insurance get stuck with the tab, paying about 128 percent of cost.

Any reform program should even that burden, but that means the early savings from cost control will go to those who buy private insurance. That will be good for the economy, reducing the health-care cost burden on companies and workers. But it won't do the federal budget any good.

Mr. Clinton seems to be taking his cues from his Rhodes Scholar colleague and longtime friend Ira Magaziner, who has been named a senior adviser in the White House. Mr. Magaziner – who couldn't be reached for comment – is a high-powered analyst who believes the health care system is riddled with such massive inefficiencies that it is possible to squeeze costs quickly, and reap benefits for the government. He participated in a study in his home state of Rhode Island that found only 50 cents of every dollar spent on health care went to heal the sick – the rest went to administrative costs.

But the view that health reform can cut the deficit in the short run doesn't sit well with other health care experts, even those who were strong supporters of Mr. Clinton. "Canute thought he could hold back the tides," says Henry Aaron of the Brookings Institution, a sometime adviser to the Clinton camp, who cited the Danish king when asked about Mr. Magaziner's views.

Indeed, many reform advocates say the health care reform plan will have to spend billions of dollars in the short run to provide health care coverage to the uninsured before savings kicks in. Democratic Rep. Jim Cooper of Tennessee, an advocate of the "managed-competition" approach that Mr. Clinton favors, says the bill he's sponsoring "is one of the cheapest bills, and it still requires $30 billion a year in new revenue."

To ensure the reform plan meets his goals, Mr. Clinton has asked his wife to head up the White House effort drawing up the plan, and Mr. Magaziner to serve as chief adviser. If he wants them to produce a plan that claims to save tens of billions of dollars over the next five years, no doubt they will.

But there are two grave dangers. First, the result could be bad health care policy. Creating an effective system of managed competition in the U.S. health care industry is a task on a par with making capitalist economies out of the formerly socialist countries of Eastern Europe. If the government demands results too quickly, it may ensure the failure of reform.

Second, by claiming savings for health care reform over the next five years Mr. Clinton may be trying to avoid making the tough budget decisions needed to get the deficit under control. If that happens, health care reform will become this year's magic asterisk – promising savings that never materialize.



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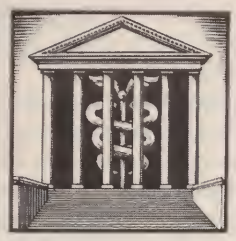
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Malpractice Roundup

PAGE 10

ISMIE Update

Case in Point examines mammography

PAGE 10

Discerning the real reason your patient seeks care

Time spent listening to patients can help physicians make more accurate diagnoses.

You've spent 20 minutes taking Mrs. Smith's history, examining her, asking questions about her health and her family, making general conversation, and now you're leaving the examining room when she says, "Oh, by the way, Doctor, I noticed a lump in my breast. Do you think it might be something serious?"

It's a common scenario that can frustrate seasoned physicians and residents alike.

You are forced into making a no-win decision: You can address Mrs. Smith's concern, perhaps setting the remaining appointments behind schedule, or postpone action for another time, leaving a dissatisfied patient. What may be more frustrating, however, is the patient who never says, "By the way, Doctor," but has a concern or additional information that remains uncommunicated, a concern that voiced would help you make a more accurate diagnosis.

Why would a patient, who has voluntarily come to your office for care, withhold information or concerns that might lead to a more accurate diagnosis and treatment? Based on the results of a study by Howard B. Beckman and Richard M. Frankel, this article describes some of the many possibilities and offers suggestions on how to elicit a patient's concerns beyond the presenting complaint.

REASONS OF SHAME and humiliation may explain why patients may not be forthcoming. Patients, for example, may not raise all their worries for fear that the physician will think the problems are trivial or a waste of time – or even laugh at them. Patients may also fear being reprimanded for waiting to seek care until there were multiple concerns or perhaps months after the first symptoms began. Also, some patients may believe that illnesses represent their own inadequacies and may blame themselves for their perceived defects, according to Aaron Lazare, MD.

Why would a patient withhold information or concerns that might lead to a more accurate diagnosis and treatment?

During the medical encounter, patients are expected to reveal their "shortcomings," and many may try to protect themselves from exposure by not sharing all pertinent information. Most patients are not capable of evaluating an illness from a scientific, biomedical perspective. Seeing head lice or a sexually transmitted disease may be routine for physicians, yet patients may have difficulty dealing with the negative social stigmas of the diseases.

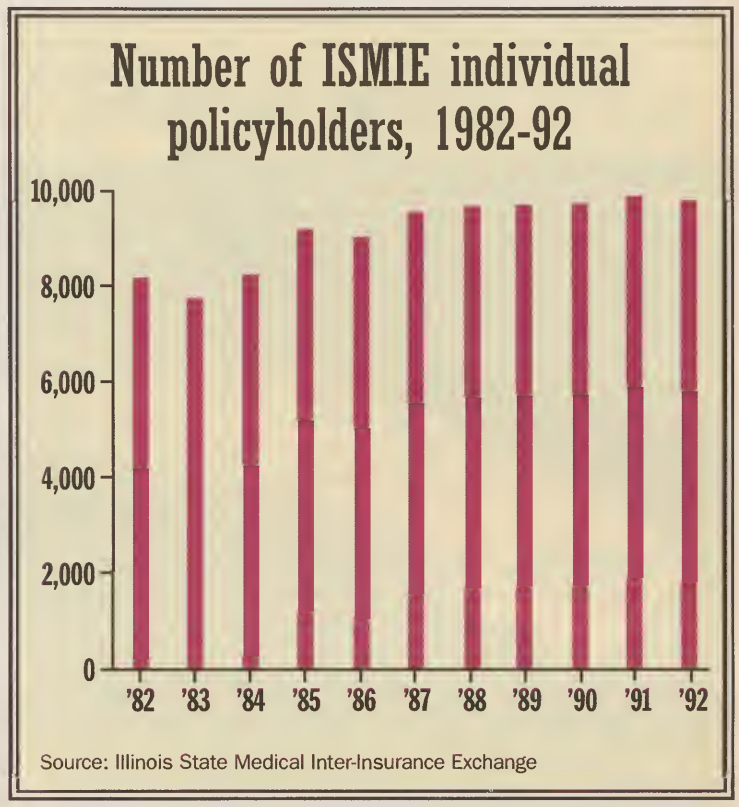
According to Dr. Lazare, empathic statements of support, such as, "I'm glad you're here to see me now," or "This illness can place quite a bit of stress on a person," are often helpful in reassuring patients that their concerns are being taken seriously and can avoid furthering feelings of humiliation.

PATIENTS ALSO VISIT DOCTORS for a variety of nonbiomedical reasons. This can be true of patients with real physical illness, as well as those without. According to Arthur J. Barsky III, MD, patients often visit physicians because they are suffering from life stress, emotional distress, psychiatric disorders, social isolation or the need for additional information about a disease that they are particularly worried about. These nonbiomedical reasons may be apparent, or they may be hidden by somatic symptoms.

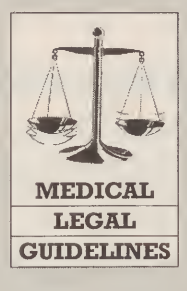
When patients present or return with symptoms that are unduly troubling them in comparison to the "norm" for the actual disease, it may mean that the real reason for the visit has not been dealt with. Patients often have beliefs about their illnesses, from the "correct" diagnosis to causes and treatments. For example, a patient may worry that he or she has the same illness that a friend or relative has, or a patient with hypertension may believe staying away from stressful situations is the only treatment necessary.

Also patients who have certain health beliefs and suspicions may not reveal them for fear of seeming ignorant. Physicians can help uncover those barriers through such questions as, "Why do you think you're experiencing this pain?" "What do you think is the cause of your symptoms?" or "It's com-

(Continued on page 11)



Determining and certifying death



The Illinois State Medical Society definition of death follows its 1992 House of Delegates policy. The policy states: "Death shall have occurred when an individual has sustained either (1) irreversible cessation of circulatory and respiratory functions; or (2) irreversible cessation of all functions of the entire brain, including the brain stem. Certification of the cause of death must be accomplished by a physician licensed to practice medicine in all its branches."

In Illinois, the legal definition of death follows Illinois case law. In 1983, an Illinois appellate court defined what constitutes death in the state of Illinois as follows: "Death is deemed to occur when a person has sustained either 1) irreversible cessation of total brain function, according to usual and customary standards of medical practice; or 2) irreversible cessation of circulatory and respiratory functions, according to usual and customary standards of medical practice" (in re: Haymer, 115 Ill. App. 3d 349, 450 N.E.2D 940 (1983)).

In 1991, the Illinois General Assembly defined death as it applies to situations covered under the Health Care Surrogate Act: "Death means when, according to accepted medical standards, there is 1) an irreversible cessation of circulatory and respiratory functions; or 2) an irreversible cessation of all functions of the entire brain, including the brain stem" (Ill. Rev. Stat. 1991, ch. 110 1/2, pars. 851-1 – 851-55).

In 1969, the Illinois General Assembly defined death as it applies to situations covered under the Uniform Anatomical Gift Act: "Death means the irreversible cessation of total brain function, according to usual and customary standards of medical practice" (Ill. Rev. Stat. 1991, ch. 110 1/2, pars. 301 – 311).

For certification, the Vital Records Act is followed. It states: "Medical certification will be completed and signed within 48 hours after death by a physician in charge of the patient's care,

(Continued on page 11)

Case in Point

Mammography follow-up critical

By Tony Sullivan

Presenting complaint and initial diagnosis: A 33-year-old woman visited a general surgeon to report a mass in her right breast.

The case in brief: The surgeon ordered a mammogram, which was taken soon after the initial visit. The radiologist reported finding no evidence of a malignant tumor, and the general surgeon informed the patient of the negative findings. About 18 months later, the patient returned to the general surgeon to again report a mass in the same area of her right breast. The surgeon ordered a mammogram and biopsy. The same radiologist interpreted these tests and reported a malignancy. Another physician performed a right radical mastectomy and a bone scan. The woman was classified as having stage III cancer and began chemotherapy and radiation treatment.



The resulting claim: The woman sued the general surgeon and the radiologist for failure to diagnose breast cancer, which led to a mastectomy.

The outcome of the claim: The claim was settled for $485,000.

The points this case makes: To be done correctly, mammography requires several people to correctly perform a set sequence of events, according to Peter M. Jokich, MD, associate professor of radiology at Rush Medical College, Chicago, and director of breast imaging at Rush-Presbyterian-St. Luke's Medical Center.

In 70 percent of the cases in which the radiologists in Dr. Jokich's group practice find breast cancer, the patients themselves feel the lump first. And according to Dr. Jokich, in most cases resulting in lawsuits, primary care physicians ignore patients' complaints. They view the lump as a cyst or other benign growth and fail to investigate it fully and aggressively. "They don't order a mammogram," said Dr. Jokich. "They don't order an ultrasound. They do no follow-up based on a superficial assessment of the complaint. Then a year later the patient comes back with a lump, and it's cancer." That appears to have been what happened in this case, Dr. Jokich indicated.

Fred Z. White, MD, a member of the Illinois State Medical Inter-Insurance Exchange Board of Governors and its Risk Management Committee, concurred. If a patient presents with a lump or a complaint, physicians should take that to its conclusion, he said. "If you conduct a mammogram and nothing shows, and the patient continues to complain about a lump or pain, you should move to the next step, which is a sonogram, or even a breast biopsy. The thing you don't want to do is ignore it. You need to close the loop."

The woman's age, 33, may have contributed to the attending physician's decision not to be more aggressive, some experts noted. But physicians should not assume that because a patient is young, she probably doesn't have cancer, cautioned Dr. Jokich. "The incidence of breast cancer in younger groups, that is, women under 40, is increasing. You really can't ignore anybody that comes through with a probable abnormality." Paradoxically, most women who get breast cancer today don't have any of the significant known risk factors, Dr. Jokich said.

Nonetheless, some physicians are reluctant to order mammograms for younger women because they fear that radiation injury may result, Dr. Jokich said, adding that those physicians should consider using ultrasound instead. "Ultrasound is a very acceptable modality to evaluate palpable lumps in those women, because it uses sound waves, which carry no known risk," he said.

PHYSICIANS CAN REDUCE the likelihood of being sued in mammography cases by taking three important steps, suggested John Smith, a malpractice defense attorney with Pretzel and Stouffer in Chicago. First, take time to explain the legalese qualifying the radiologist's opinion, which is included on most mammography reports to patients. In essence, the language says, "Even though there doesn't appear to be a malignancy, I can't guarantee there is no cancer present." The language is designed to protect physicians, so that if breast cancer results later, patients can't claim they were uninformed about the possibility. But it can be confusing to patients.

Second, and perhaps more important, Smith said, is to document the fact that you advised the patient to have a repeat mammogram done within the recommended time frame outlined by the American Cancer Society. And third, send this information to the patient by certified mail, return receipt requested. Patients who sue for malpractice involving mammography often claim they were never informed of follow-up recommendations by mail or in a phone conversation, Smith said. The registered mail can give you a solid defense that you did, in fact, communicate those recommendations and that the patient received them.

Informing the patient of the results of the mammogram and your recommended follow-up is another critical risk management step physicians can take, Dr. Jokich added. It also provides an opportunity to notify the referring physician about test results. "In biopsies, for example, we call the patients in, show them the images, tell them what we see and what we think they should do – call your doctor, follow up with him, see who he wants to refer you to, see whether he agrees with us, and then come to some conclusions," said Dr. Jokich. "If patients haven't heard from the doctor in three or four weeks, they know something has fallen through the cracks. They know they need to have a procedure done, so they can contact their doctor."

Attending and consulting physicians should also be sure to communicate with each other in cases involving mammography, Dr. Jokich added. Lawsuits involving failure to communicate test or procedure results to a referring physician or a patient are increasing, which raises a key question: What is the radiologist's obligation to the attending physician?

That's a matter of judgment, Dr. Jokich said. "For life-threatening things we see on film, there's no question that the referring physician should be called on the phone immediately. In mammography, when you see something that looks like it may be cancer, do you need to call immediately? That's a judgment issue that people are debating."

Dr. Jokich's group practice uses a coding system that identifies cases requiring a phone call to a referring physician, as well as other follow-up action. A secretary calls referring physicians to inform them of the recommended follow-up actions, in addition to mailing them the mammography reports. The secretary records in a logbook whom she talked to, when they talked and what they talked about.

RISK MANAGEMENT EXPERTS offer several other suggestions for physicians to reduce their risk in cases involving mammography. For example, primary care physicians should

- Refer mammography cases to radiologists who are experienced at interpreting mammograms and can make sound judgments on the need for biopsies when there are questionable lesions.
- "Close the loop" on patient complaints by taking those complaints to their furthest points.
- Initial the mammogram report and the results of all other tests or procedures to verify that you have seen the results and reported them to the patient.

To reduce their risk of lawsuits, radiologists should

- Gather all the appropriate information needed to perform the mammogram before doing the procedure. Get an accurate written description from the referring physician about what you should look for in the mammogram. Have patients complete written questionnaires about the purpose of the mammogram and about previous biopsies, lumps, nipple discharges, skin scars, or moles, each of which can affect your ability to accurately interpret the film.
- Communicate the results of the mammogram in written reports to the referring physician. If the results indicate the need for further workups or biopsies, call the physician. Mail written reports to referring physicians in these and all other situations.

Physicians should also use the most aggressive guidelines when counseling patients on follow-up mammograms, according to risk management experts. For example, the current guidelines from the American College of Radiology and the American Cancer Society call for a baseline mammogram at age 35, a mammogram once every two years between ages 40 and 50, and yearly mammograms after 50.

Case in Point is a regular feature using hypothetical case histories to illustrate loss-prevention maxims. ■

MALPRACTICE ROUNDUP

Educating patients can reduce liability

According to the newsletter *Loss Minimizer*, educating patients about the scope and limitations of medical care and about their responsibilities in the doctor-patient relationship effectively deters malpractice litigation. Many malpractice specialists believe that patients sue primarily because they do not understand what physicians and medical science can and cannot do for them. An inadequate understanding of medicine can lead patients to mistake a bad outcome for bad care.

The newsletter suggests several areas of health care in which patient education is essential, including surgery, medications, cancer, new diseases and discharge instructions. Physicians are encouraged to be sensitive to patients' fears about their health and especially their mortality. Education can improve the doctor-patient relationship, increase patient confidence in physicians and significantly reduce physicians' malpractice liability exposure. ■

Study says malpractice defendants better off with a jury

Although malpractice defendants and their lawyers have traditionally favored a trial before a judge, recent research may have them rethinking that preference. According to a study published in the *Cornell Law Review*, judges, not juries, may be more likely to side with plaintiffs in several categories of personal injury lawsuits, particularly medical malpractice. Examining the outcomes of federal lawsuits tried between 1978 and 1989 the authors found that plaintiffs prevailed in 50 percent of cases heard before judges, compared with only 29 percent of cases that went to juries. The authors suggested one reason may be that juries are far more likely than judges to trust a physician's competence and give him or her the benefit of the doubt.

As reported in *American Medical News*, the study also dispelled the myth that juries grant larger awards. Winning plaintiffs were awarded an average of $1.4 million in jury cases, compared with an average of $1.44 million awarded by judges. ■

Communication

(Continued from page 9)

mon to be concerned about what might be wrong. What are your concerns?"

THE TRADITIONAL DECISION tree approach itself can be a barrier to discerning the real reason for the patient's visit. Physicians are trained to identify the chief complaint. However, Robert C. Burak and Robert Carpenter, MD, found that the presenting complaint, which steers the beginning of many medical interviews, was not the principal problem in 40 percent to 50 percent of cases.

Beckman and Frankel found that when a patient was encouraged to express concerns until the patient said there were no more to add, significantly fewer concerns were raised at the end of the interview.

Another Beckman study found, however, that physicians, on average, interrupt patients 18 seconds after the initiation of dialogue. In fact, in only 23 percent of studied visits was the patient allowed to complete his or her opening statement. Yet, given the opportunity to speak uninterrupted, no patient took more than 2½ minutes to complete a statement.

Research also shows that following an interruption, the physician took control of the exchange 94 percent of the time. Only one out of 52 patients went back to the point he or she was raising when interrupted.

Contrary to the belief that responding to patients' statements with such phrases as "mmh hmh" or "go on," adds little to the exchange, these comments actually encourage patients to raise a range of topics. Surprisingly, repeating the patients' last statement encourages them to elaborate only on that issue, not to move on to the next. Similarly, closed-ended questions, often used in hypothesis testing, only allow for short answers on one issue.

It is important to keep going back to such questions as, "Is there anything else you'd like to discuss?" "Are there any other reasons you came to see me today?" or "Was there anything else you were hoping I could help you with today?"

Most patients seek care to help "cure" what ails them. However, patients often don't realize how their own beliefs and concerns can hamper the physician's efforts. A therapeutic physician-patient encounter, therefore, relies not only on the physician's clinical skills, but also on his or her communication skills. ■

Reprinted from Comment *newsletter, with permission from the Miles Program for Physician-Patient Communication.*

Death

(Continued from page 9)

except when the death is subject to the coroner's or medical examiner's investigation. In the absence of the physician or with his approval, the medical certificate may be completed and signed by his associate physician, the chief medical officer of the institution in which the death occurred or by the physician who performed an autopsy. The death will be registered by filing the death certificate within seven days after such death, with some exceptions. When there is no medical attendance, the coroner or medical examiner will be responsible for the death certificate" (Ill. Rev. Stat. 1991, ch. 111 1/2, par. 73-18).

Questions arise about whether facility staff may determine death. According to guidelines from Morse, Giganti & Appleton dated December 1990, some facilities authorize nursing staff to determine death and note it in the chart. Consequently, the official legal declaration of death is made when the death certificate is completed by a physician. However, in executions a defendant sentenced to death shall be executed until death is pronounced by a licensed physician according to accepted standards of medical practice (Ill. Rev. Stat. 1991, ch. 38, par. 119-5). The Illinois attorney general's office stated in a July 1, 1992, letter that "only a licensed doctor is qualified by training and experience to determine when an individual's heart and brain functions have stopped and death has in fact occurred. The law only requires a doctor to perform a function which he or she regularly performs in the course of medical practice." ■

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The Illinois State Medical Inter-Insurance Exchange will again offer "Taking Control: Managing Your Malpractice Lawsuit."

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ALTERNATIVE MEDICINE

Toward the unconventional

Responding to patient demand for more health care options, some physicians are choosing alternative paths to treatment.

BY ANNA BROWN

Alternative medicine, it's called. Unconventional medicine. It has been criticized, shunned and very seldom studied.

What is known is that more patients are turning to alternative therapies. According to a recent study published in the *New England Journal of Medicine*, in 1990 one in three American adults used unconventional therapy for serious medical conditions, spending $13.7 billion to visit alternative providers.

Perhaps the least surprising but most alarming finding of the study, conducted by David M. Eisenberg, MD, of the division of general medicine and primary care at Beth Israel Hospital in Boston, is that patients rarely tell their physicians about their use of unconventional therapies.

A Chicago internist recalled that in the past his patients reluctantly confessed their visits to alternative practitioners and their improvement as a result. He would ask, for example, if a patient with chronic back pain had considered seeing a chiropractor, only to find that the patient had been seeing one for years.

"In their minds, patients had two primary care physicians, and I didn't know of the other's existence," said David Edelberg, MD, the internist whose Chicago Holistic Center opened on the North Side in mid-January. "I began to see the necessity of asking them, and I began including it in patient histories, which is what the new study advised. It was something I had been doing for a long time."

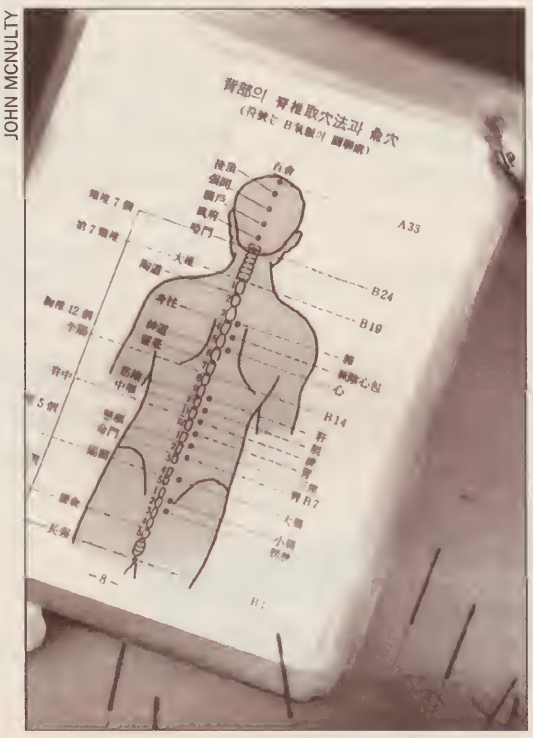
Dr. Edelberg's new clinic is a result of the curiosity about alternative medicine he gained from his patients. He learned about various therapies, including acupuncture, and eventually began referring patients to alternative practitioners. He always told them, however, that if they felt they weren't improving or felt worse, they should return to him. "Patients were very happy with this approach. They liked my open-mindedness," he said.

The Chicago Holistic Center employs 51 traditional and nontraditional practitioners on a time-share basis, and encompasses 32 health care fields. The center gained quick publicity after being featured in an article on alternative medicine in the *Chicago Tribune Sunday Magazine*. Since then, the practice has been brisk.

Two types of patients typically visit the center, Dr. Edelberg said. The first is made up of those who are chronically ill and seeking treatment for pain or to gain a "sense of hope." Patients in the second group are "health-oriented and don't want mainstream care.

"These people have taken all the responsibility of health care very seriously" continued Dr. Edelberg. "Their diet is exemplary, they exercise regularly, they have jobs they enjoy, they have excellent interpersonal relationships. These are the people who are going to live to be 100 years old. They want this to be their home base. I tell them, 'The less I see you, the better. You're fine. You're doing all the right things.'"

Dr. Edelberg spends the most time with chronically ill patients. As the center's facilitator, he reviews new patients' records and refers them to the practitioner he thinks will be most useful.



JOHN MCNULTY

DR. EDELBERG SPEAKS of the Chicago Holistic Center as a bridge that spans traditional and alternative care.

"I don't in any way want to have a person abandon conventional care. That is

totally against the spirit of the center.

"I would like medicine ultimately to be transformational," Dr. Edelberg continued. "We're far too preoccupied with repairing the damage people have done to their bodies."

The center is affiliated with Columbus Hospital in Chicago, which rents Dr. Edelberg the office space. When he presented the idea, the hospital was initially skeptical, but has since been supportive, he said. He chose practitioners with years of clinical experience.

"Somebody who's not very health-conscious is not going to be happy in this center," said Dr. Edelberg. "We place a great deal of demand on the patient. This center is for people who are taking on a sense of responsibility about their well-being."

A team approach to medicine is stressed at the center, with practitioners often working together and referring to each other. Holism, a combination of "healing" and "wholeness," emphasizes education, personal responsibility and cooperation between the patient and practitioner. "We will take care of the whole patient using some alternative approaches if needed, but I ask the patient to become a participant and a member of the team."

Physicians who use alternative treatments in their practices are increasing, but are still relatively few. Nevertheless, because they have the necessary training, experience and licensure, only MDs and DOs are qualified to diagnose and treat all medical conditions. To ensure the highest-quality care, state law and Illinois State Medical Society policy mandate that alternative care not be provided in lieu of physicians' care or without physician supervision.

A GROWING PRACTICE, which has gained almost mainstream acceptance, especially among psychiatrists, is hypnosis. MDs practicing hypnotherapy are usually members of the Des Plaines-based American Society of Clinical Hypnosis. The society requires a doctorate degree, such as an MD or DDS, or a masters degree in social work or specialty nursing. It offers training and workshops throughout the country, and its programs are accredited by the Accreditation Council for Continuing Medical Education.

"This is not a lay organization," said William Hoffman, ASCH executive vice president, explaining that the 20,000 membership includes medical professionals only. Founded in 1957, the organization will begin offering official certification in hypnosis next year.

Bennett G. Braun, MD, a psychiatrist and former general practitioner, uses hypnosis as an adjunct to medication in his Skokie and Chicago practices. He cautions against the use of hypnosis by non-MDs because of the potential for harm. In his practice, Dr. Braun uses the procedure to treat a large number of ailments including phobias, anxiety disorder, depression and pain. It can also be used to treat dissociative disorders such as multiple personalities and post-traumatic stress syndrome, he said.

> *Somebody who's not very health-conscious is not going to be happy in this center. We place a great deal of demand on the patient. This center is for people who are taking on a sense of responsibility about their well-being.*
>
> **– David Edelberg, MD**
> **Chicago Holistic Center**

Dr. Braun explained that even demonstrations of hypnosis can be dangerous if conducted by a lay therapist. For instance, in cases of age regression, in which the therapist takes the individual back to a younger age, hypnosis participants could inadvertently re-experience a traumatic situation, such as child abuse.

Another potential problem can occur after physicians teach patients self-hypnosis to control pain. Patients may begin to mask symptoms of disorders that require other treatments. "Hypnosis is a powerful analgesic that can cut pain out," Dr. Braun said. "Patients should use it only for pain they understand." Through hypnosis it's possible to relieve pain that really requires medical attention, such as broken bones, he said.

Dr. Braun also uses biofeedback in his practice, but only when hypnosis fails. "Biofeedback and hypnosis are two ways of getting to the same place," he noted. Both involve deep relaxation, but biofeedback uses equipment to measure body changes, such as muscle relaxation. Biofeedback patients learn to control their bodies through reinforcement.



JOHN MCNULTY

A.A. Sattler, MD, a semi-retired pediatrician, uses hypnosis to help children cure themselves.

A retired pediatrician who has used hypnosis for behavior modification in children for the past three years believes that alternative medicine has not been readily accepted by physicians because of the time needed to devote to each patient. A.A. Sattler, MD, whose Niles practice ranges from bed-wetters, thumb-suckers and nail-biters to hyperactive children and asthma patients, spends two hours with each child on the initial visit. Dr. Sattler said taking so much time with patients would be cost-prohibitive for other practitioners, but he is able to do so because he is semi-retired. After carrying a full load of patients for 30 years, Dr. Sattler now sees three or four children a day.

To put patients at ease Dr. Sattler refers to himself as an "operator" rather than a therapist. He also has a large collection of toys for his patients, and uses intercoms and a two-way mirror to keep the parents involved if the child does not want them to stay in the room.

Hypnosis not only treats the problem, but helps children feel good about themselves, Dr. Sattler said. He stresses to patients that they cure themselves. "You did it," he tells them.

Dr. Sattler also uses the team approach, incorporating the parents and the patient in the healing process. Because of his medical background, Dr. Sattler always screens patients for problems that must be treated medically by taking complete biological, psychological and social histories. He considers his practice completely adjunctive to the work of other practitioners.

"All hypnosis is self-hypnosis," Dr. Sattler said. "It's a question of self-motivation. It is focused attention on the problem."

EVEN FEWER PHYSICIANS practice acupuncture than hypnosis. However, ISMS policy states that only licensed physicians should practice acupuncture. Patients have definite benefits when they seek acupuncture from a physician, said Julian Chestnut, DO, DVM, an anesthesiologist and acupuncturist who practices in Rockford. For example, when patients come to him suffering from headaches, he makes sure the problem isn't a serious one, like a tumor, before treating them

(Continued on page 14)

Alternative medicine

(Continued from page 13)

with acupuncture.

"Acupuncture is a growing alternative because it works," said Dr. Chestnut, explaining that its acceptance is growing since medicine has found a way to fit it into a Western paradigm. Previously, the Eastern paradigm of energy flows and blockages was the only explanation for how acupuncture works. The insertion of needles at key points would unclog the energy flows to promote healing of a particular problem. "This is not entirely off-base," said Dr. Chestnut, noting electrical charges between cells.

"Interestingly enough, Chinese medicine has no nervous system," he added. The theory of energy flow is 4,000 years old and was brought to Europe by French Jesuits, who found that acupuncture worked better than their own medical efforts.

The Western paradigm, which is now well documented, according to Dr. Chestnut, establishes that electrically stimulated needles cause pain receptor sites in the brain to produce endorphins, which reduce pain and promote healing.

Dr. Chestnut studied acupuncture in a year-long program offered by the University of California at Los Angeles and developed by Joseph Helms, MD, president of the American Academy of Medical Acupuncture. Finding little resistance from his peers, Dr. Chestnut said other physicians send him patients who have frustrating problems. "I'm an out for them," he said.

Some physicians saw Dr. Chestnut for acupuncture treatment themselves, and when they found the treatment helped, they referred patients to him.

RECENT DEVELOPMENTS such as the *New England Journal of Medicine* study and the opening of the National Institutes of Health Office for the Study of Unconventional Medical Practices have opened alternative medicine to a lot of publicity and have intensified the debate over its validity. Should such practices as naprapathy and homeopathy be scientifically analyzed? Can acupuncture and hypnosis survive double-blind studies?

And what are the standards for alternative medicine and its practitioners? Should they be held to standards of care comparable to those for traditional medicine? Although these questions have not yet been answered, more research may be in the works.

The new NIH office may facilitate such research. "There's so much we don't know about the mind-body connection," said Dr. Edelberg, who has submitted a grant proposal to the new office. "What has been dismissed as the placebo effect, which I think is a very pejorative phrase, says that what a practitioner does is nonsense and the patient is as deluded as the practitioner. If you can accept the fact that the patient's getting well is a reasonable end point, then allow it and fund some studies. But I don't think we're going to find the same double-blind controlled results in alternative medicine. We have to accept that there are going to be some different views required of the judges of the studies. They'll have to transform themselves as well, and that's going to be hard." ■

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Computers

(Continued from page 5)

IF THE FEDERAL GOVERNMENT has its way, that is exactly what will happen to the health care industry in the future. Louis W. Sullivan, MD, former secretary of the U.S. Department of Health and Human Services, has already outlined plans for a national electronic health care billing and information system, to be put in place as early as 1994. Dr. Sullivan estimated that this computerized system could save as much as $114 billion in health care costs from now until the year 2000.

In addition, Medicare providers submitting claims electronically can be paid as much as two weeks faster, Dr. Sullivan said.

"These actions will establish a strong incentive to submit Medicare bills electronically," he said.

Dr. Kopp agreed. "By using my computer, my billing is done promptly, and I receive Medicare and public aid payments more quickly," she said. "I am probably one of the few doctors getting public aid checks regularly."

Although the Illinois State Medical Society supports the idea of a national electronic billing system, it believes physician participation in such a system should be voluntary, and those who choose not to participate should not be penalized.

Despite the many advantages of computerization, physicians may still be wary of making the computer switch. Many believe computers are too complex and confusing. "It takes time to learn, but the system is user-friendly even for those with no computer experience at all," said Postlewaite.

Dr. Ramos added, "Many physicians are not willing to accept innovations, but if [they] want to be prosperous [they] must accept these innovations." ■

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Scarcity of women in research hinders patient care, group says

Roundtable participants discuss aspects of patient care they believe have suffered because past clinical trials have omitted women participants. By Tamara Strom

On June 18, 1990, a revolution in patient care occurred. The women's health movement began.

On that day, the nation's attention focused on a glaring omission: No women were used as research subjects in clinical trials funded by the National Institutes of Health. Using a General Accounting Office audit, U.S. Senate hearings scrutinized the dearth of federally funded research that included women.

In the 33 months since then, some members of the medical community have begun taking steps – including forming advocacy groups – to identify the problems created by the "womenless" study designs. One such group is the Society for the Advancement of Women's Health Research, a national organization based in Washington, D.C., dedicated to increasing the visibility of women in research – both as researchers and research subjects. During a February roundtable sponsored by the society and held at the University of Chicago Hospitals, Chicago-area physicians, health care administrators and academicians discussed the legacy of medical research based on a male model of disease.

"The status of patient care has suffered" because of the exclusion of women from research studies, said Anne Colston Wentz, MD, a reproductive endocrinologist at Northwestern University. "Women have gotten the short end of the stick in research."

Dr. Wentz enumerated several "glaring examples" of gender disparity in research and medicine. She said the now-famous aspirin study on coronary artery disease in physicians is currently cited as often for its omission of women as for its clinical significance. The study used 22,071 male physicians and not one woman, Dr. Wentz said.



AMY ROTHBLATT

Among the Chicago-area physicians discussing women's health research during a February roundtable were (from left) Mary Louise Tomyanovich, MD, chief of neurology at the Westside VA in Chicago; Anne Colston Wentz, MD, a reproductive endocrinologist at Northwestern; and Nancy Lance, MD, assistant chairman of internal medicine at Rush-Presbyterian-St. Luke's Medical Center.

This lack of gender-specific information about women and coronary artery disease is dangerous, since heart disease is a leading cause of death among women, Dr. Wentz said. To illustrate her point, she paraphrased NIH Director Bernadine Healy, MD: "The problem is to convince both the lay and medical sectors that coronary artery disease is also a woman's disease, not a man's disease in disguise."

THE MEDICAL LITERATURE shows that men are twice as likely to receive medical intervention or diagnostic testing for coronary artery disease even though a woman's symptoms are as severe as a man's, Dr. Wentz said. Once tested and diagnosed, men and women receive equally high-quality care, she said, but women have less access to initial testing.

Begun in 1958, the Baltimore Longitudinal Study on Aging was also designed without female participants, Dr. Wentz said. The exclusion of women parallels the earlier omission of elderly patients from trials because researchers claimed older people "have more than one disease, which muddies the research," said Christine Cassel, MD, a gerontologist at the University of Chicago and roundtable participant. Dr. Cassel said past excuses for failure to include women in studies, such as the higher cost of running the trial, are no longer acceptable. "We must examine the cost of treating people in the absence of knowledge," she said.

Other participants, including Samuel Hellman, MD, dean of the University of Chicago's Pritzker School of Medicine, which co-sponsored the roundtable, also expressed concern about economic arguments driving research. Dr. Hellman said he fears economics may play too large a role in health care. "We must be careful not to measure women's health or health care in general by economics," he said.

LESS THAN HALF of the therapeutic drugs now on the market have been analyzed for gender-related effects, Dr. Wentz said. In particular, the lack of gender-specific research on psychotropic drugs could have patient-care ramifications, she said. Although depression is mainly a disease of women, and drug metabolism varies between men and women, no research exists about the differences in the effects of psychotropic drugs on male and female patients, she noted.

The health care of women with AIDS is also suffering because the disease pattern in women has not been studied enough, Dr. Wentz said. One of the most definitive ongoing AIDS studies is the AIDS Clinical Trial Group with 12,084 study subjects, she said. Of the 11,909 subjects coded by gender, only 801 are women.

At least one in five AIDS patients is a woman, but the model of the AIDS patient is a gay white male, Dr. Wentz said. Women get the disease differently than gay men: Typically, they contract it through IV drug use or sex with male IV drug users. In addition, most women with AIDS are minorities, Dr. Wentz said.

The medical community doesn't "know a lot about the natural history of the disease in women," she explained, adding that because so little research has been done on women AIDS patients, "the window of opportunity has been lost to study the natural progression." ■

ISMS in Washington

(Continued from page 1)

Thomas Ewing (R-Bloomington) and Harris Fawell (R-Clarendon Hills). They also met with Rep. J. Dennis Hastert (R-Batavia), who was just appointed to the president's reform task force, and key staff members for Rep. Dan Rostenkowski (D-Chicago), chairman of the House Ways and Means Committee.

Former U.S. Rep. Beryl Anthony (D-Ark.), now on board as a congressional liaison with Winston & Strawn, told the Illinois contingent that "there will be change" in health care. He encouraged physicians to provide input to the government. In fact, ISMS will soon submit written recommendations to the White House, including details about the mandatory reporting features of Illinois' disciplinary process and the state's experience with malpractice reform.

Anthony said the task force, chaired by Hillary Rodham Clinton, is operating under a model similar to that used by the first lady in achieving education reform in Arkansas. Although that process took several years, Clinton managed the reform initiative to fruition. ■

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Senate leader

(Continued from page 1)

just the person the majority party happens to pick to lead them. The real significance, for the public, comes from the ability of the majority party to influence public policy."

Among the notable changes Illinois physicians might expect is a friendly Senate reception to legislation calling for caps on noneconomic damages. "For the first time in more than a decade, Republicans who support tort reform will be on an even footing with Democrats who don't," Philip noted. "We'll be able to sit across the table from one another as equals. That's no guarantee that we'll win some concessions, but it certainly puts us in a better position than in the past."

Citing a 290-percent increase in malpractice payouts during the past 10 years, Philip said there is "no question" in his mind that tort reform is a serious issue in Illinois. "When doctors are paying $60,000 to $70,000 for malpractice insurance premiums, how can you pretend it isn't a problem? My downstaters tell me they are particularly concerned because the high costs are driving doctors out of rural areas. We can't keep this up."

But the Senate president is realistic about the political realities of passing tort reform measures with a Democratic House of Representatives led by Speaker Michael Madigan of Chicago. Philip said a Democratic House means a legislative body "firmly under the control of the litigation lobby."

Despite the seeming gridlock in the Statehouse caused by different parties' control of the legislative houses, Philip said he is confident he and Madigan will be able to "negotiate on controversial issues" such as tort reform. "Mike and I have always had a good relationship. We're both practical guys. He comes to the table with his list, and I come to the table with mine. We sit down and work things out. That's how I approach government, and I think that's how he approaches it too."

> *Philip said there is 'no question' in his mind that tort reform is a serious issue in Illinois.*

Even if the legislature does not enact a cap this year, at least the Senate will be able to block any ill-conceived proposals that would further erode the liability situation in Illinois, Philip said. "I hear all the time from my friends in the business and medical communities that yes, they'd like to see the liability system reformed. But, they say, 'At least don't do anything to make matters worse.' I can guarantee that that won't happen under Republican control in the Senate."

A SINGLE-PAYER, GOVERNMENT-FUNDED universal health system for Illinois is probably a dead issue this year given the Republican stronghold on the Senate, Philip said. The Democratic-pushed plan from last year was "so expensive that the sponsors were embarrassed by their own bill," he noted, adding that the cost of the proposed system would have been more than double the entire state budget.

"It would have made Illinois a magnet for people in other states without health insurance, and it had absolutely no controls on it. It was a terrible idea and died the quick death it should have," Philip said. "I hope that under Republican control we will see a lot fewer of these wild, impractical and tremendously expensive ideas out there. We need to work on real solutions."

The lack of meaningful tort reform in a universal health proposal dooms it to failure, Philip added. The plan floated by the Democrats the past few years is, in reality, unlike the Canadian system of universal access its supporters purport because it lacks limits on malpractice suits, he explained. Foreign health care plans such as Canada's "recognize that tort reform has to be a part of any universal system or they will never work. But all tort reform was left out of the Illinois proposal."

MEDICAID FUNDING is a controversial and complicated issue that Democratic and Republican lawmakers alike must face in the upcoming legislative session. Philip said it is "no secret" that he didn't like the health care facilities assessment program the General Assembly approved last year. "There wasn't any real alternative, but I still was not enthusiastic. I don't think anyone was, including the governor, but he took the lead on it because the only other choice was to leave a multi-million-dollar hole in the budget."

Philip said he will be looking for alternatives this year to replace the hospital and nursing home tax to continue to adequately fund the Medicaid system. Among the options he has heard discussed in Springfield are more broad-based taxes and a revival of the sales tax on food and prescription drugs. Although Philip said he "doesn't know" what course he'll ultimately recommend, he is keeping his "options open and listening for ideas."

A STREAMLINED COMMITTEE SYSTEM is another area in which Philip plans to make his mark in the Capitol. New rules have already been adopted to strengthen the committee process, he said, which in turn bolsters the power of committee chairmen. In addition, Philip has reduced the number of committees from 23 to 15 and loosened the grip of lawyers on the chairmen's posts.

Whereas the Democrats had appointed as committee chairmen "14 professional politicians, seven lawyers, one employee of the city of Chicago sewer department and only one businessman," the Republicans have put in place "two farmers, a pharmacist, a firefighter, three businessmen, a retired businessman and only two attorneys and five full-time legislators," Philip explained.

"I think the diversity is good for Illinois," he said. "It brings a broader range of viewpoints to the process and helps us keep in touch with the real people out there." ■

Mini-internship

(Continued from page 1)

Madison, Macon, McLean, Peoria, Rock Island, Sangamon, St. Clair, Tazewell and Will-Grundy counties. The program is coordinated through county medical societies.

A day that may seem routine to physicians can leave a lasting impression on their interns. During hospital rounds, office visits and surgery, interns see the realities of practicing medicine: the mounds of paperwork, the large support staffs and the restrictions placed on physicians by government regulations. This experience benefits physicians as well as their interns.

MOST IMPORTANT TO MEDICINE, the mini-internship program helps ISMS and individual physicians and auxilians strengthen their relations with state and federal lawmakers. Since the program's inception, more than 52 local, state and federal legislators and other public health officials have participated. The relationships that are established during the day often last much longer. Participating physicians and auxilian coordinators become valuable sources of information over the long run for their legislator-interns, who come to their hosts with questions about how proposed legislation may affect physicians and their patients.

In some cases, the program has helped medicine win new friends in the Illinois General Assembly. Legislators who once were reluctant to consider medicine's point of view now seek physicians' opinions on health care-related legislative matters. With so many newcomers elected to the General Assembly this year, the mini-internship program will help ISMS educate freshmen legislators on medical issues.

IN ADDITION TO opening the channels of communications between physicians and legislators, the mini-internship reveals to interns the hidden factors driving health care costs. Working side by side with physicians, interns observe how the threat of lawsuits overshadows decisions regarding patient care, forcing physicians to practice defensive medicine. They often meet with the support staff to better understand the amount of time devoted to paperwork and phone calls from third-party payers, and the costs associated with government regulations. Such information illustrates that health care costs are everyone's responsibility – not just physicians' – and that costs can be controlled only with cooperation from all parties involved.

Media participating in the program help ISMS educate the public about the realities of practicing medicine today. Fifteen reporters who have completed the program have written stories about their experiences for their local newspaper or for a television broadcast. In addition, local media have covered several of the programs, interviewing interns for their new insight into the problems of the nation's health care system.

Education is the most powerful tool physicians have in shaping public opinion and influencing health policy. The mini-internship program educates legislators, business and community leaders, and the media to the realities of medicine through firsthand observation. ■

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Disciplinary process

(Continued from page 3)

members contend. This is due in part to mandatory reporting provisions included in the statute after a comprehensive rewrite in 1987. The revision was accomplished through a collaborative effort of the General Assembly, IDPR and ISMS. In fact, ISMS supported a tripling of state licensing fees for physicians, from $100 to $300, to fund more-comprehensive investigation of complaints.

State law mandates that any action taken against a licensed physician by a health care institution, professional society, malpractice insurer, state's attorney or other state agency be reported to IDPR. These actions include restrictions or terminations of hospital privileges, jury verdicts or settlements in malpractice cases alleging negligence, and felony convictions. These reports are considered by the board's Complaint Committee, which by law includes at least two board members. However, Dr. Ray said he named seven members to the committee to provide "more input from other physicians."

If the Complaint Committee believes a practice act violation may have occurred, the case is referred for further action. When no violation is substantiated, the case is closed.

MANDATORY REPORTS are only one avenue through which potential disciplinary cases enter the system, Dr. Ray said. Complaints from the public are the other.

"All of the complaints filed are reviewed thoroughly by the department's investigative unit," he said. "All complaints are given the proper attention and undergo investigative procedures to determine if they are valid or not. No complaint is ever just thrown out."

The investigative process includes in-person interviews with the parties involved, IDPR said. No formal record of the discussion is made. Instead, the investigator writes a report based on what was said. In addition, the investigators compile any necessary supporting documentation such as medical records and court documents. The investigative findings of the alleged violation are then forwarded to the Complaint Committee.

Once the committee reviews the case, it can either substantiate that a violation of the practice act occurred and refer the case for prosecution or, finding no violation, simply close the case. Board Vice Chairman Boyd E. McCracken, MD, said he encourages physicians to provide input to the Complaint Committee and department investigators when asked. If physicians were a "little more forthcoming in giving their side of the facts" during early stages of the process, some cases could be resolved sooner, he said. "If a physician does not respond, we don't have much choice but to investigate.

"We don't want physicians reprimanded without due process, and we make every effort to ensure that fairness prevails," Dr. McCracken added. "But we don't want any serious situation to go unreckoned with."

However, if a case is referred, it then undergoes a "careful, comprehensive hearing process," Dr. McCracken noted. The facts of the case are reviewed during an informal conference by the responding physician with his or her attorney and a board member with the department's legal counsel. Although a lay member of the board may be designated as the representative at an informal conference, if there is any question requiring technical expertise, a physician board member will be consulted, he said. "No medical decision making is made by nonphysicians."

In most cases, an agreement about appropriate action – such as remedial education, probation or suspension – is reached during the informal conference. The responding physician then has two weeks to consider whether to accept the terms of the agreement. When the physician agrees to the terms, a consent order is returned to the full board for consideration. If the board concurs with the recommendations, it so moves and forwards its decision to Zollar for final approval.

However, if the informal hearing fails to yield an agreement, the physician can request a formal hearing before an administrative law judge, Dr. Ray explained. After a full hearing, the judge forwards his or her recommendations to the board, which then examines the proceedings and makes its own recommendations to the director. If disciplinary action is taken that the physician believes is inappropriate, he or she may appeal in court.

"There are checks and balances every step of the way," Dr. McCracken said. ■

Percent of Illinois physicians disciplined 1988-91*

1988	1989	1990	1991
0.7	0.8	0.9	0.54

U.S. average: < .5 percent

*Based on an average of 26,600 licensed physicians

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)
CONTRAINDICATIONS
Hypersensitivity to any component of this medication.
Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).
Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.
WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.
As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.
Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.
Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**
The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**
PRECAUTIONS
General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.
Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.
Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.
Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.
Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.
Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.
Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)
Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.
Cimetidine: The $AUC_{0\text{-}12h}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.
Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.
Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.
In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.
Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.
Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.
CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.
A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.
Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.
The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.
A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.
No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae.* In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.
In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.
Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.
Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.
Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).
Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)
ADVERSE REACTIONS
Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.
Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.
The following effects have been reported with drugs in this class:
Skeletal: myopathy, rhabdomyolysis.
Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.
Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.
Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.
Reproductive: gynecomastia, loss of libido, erectile dysfunction.
Eye: progression of cataracts (lens opacities), ophthalmoplegia.
Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).
Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.
Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)
OVERDOSAGE
There have been no reports of overdoses with pravastatin.
Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MARCH 26 1993

Public health, employee health plan reap budget benefits

PAGE 4



Medical degrees within reach for minority students

PAGE 12



Chip Zellett

ISMS PRESIDENT ARVIND K. GOYAL, MD, talks to patient Audrey Moen and her son, Jordan, at HealthReach Clinic in Waukegan. About 18 area physicians volunteer at the clinic for the underserved, which has treated about 1,700 patients since it opened in May 1992.

Supplemental appropriations would benefit patient care

FISCAL '94 BUDGET: Medical obligations make up the lion's share of Gov. Jim Edgar's supplemental GRF recommendations. By Tamara Strom

[SPRINGFIELD] Although Illinois is climbing out of the recession, the state's economic picture still has some stumbling blocks. The current fiscal year budget will fall short again, precipitating Gov. Edgar's call for supplemental appropriations, many to cover overdue medical bills.

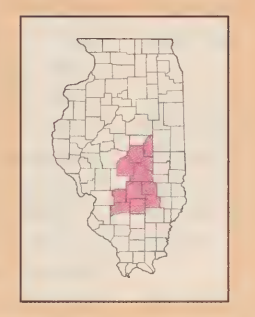
The governor is requesting more than $1.1 billion in supplemental spending, but most of that is necessary to cover the principal and interest on the short-term loans the state took out last year, said Bureau of the Budget spokesperson Ellen Feldhausen. "This is why the

(Continued on page 17)

INSIDE

Downstate district jumps into action

PAGE 5



Electronic messaging to enhance service

PAGE 11

DEPARTMENTS

News Briefs....2, 3
Commentary...6, 7
ISMIE Update 9
Members in the News.....14
Classifieds 15
Obituaries 19

Allied health workers seek more autonomy

EXPANDED FUNCTIONS: Bills submitted by allied health workers would expand the scope of their practices. By Tamara Strom

[SPRINGFIELD] Of the more than 3,500 new bills that made the March 10 introduction deadline, several will keep organized medicine lobbyists busy because they have implications for patient care delivered by allied health workers. Among the groups this year backing bills to expand their practice are the optometrists, chiropractors and lay midwives.

To ensure patient-centered high-quality care, physicians traditionally believe that a team approach to health care delivery is the most desirable. However, ISMS policy states that the health care team must function under the leadership of physicians who have the necessary skills and education to fully coordinate a patient's care. Without an integrated treatment plan, nonphysician health care professionals could deliver "isolated, fragmented" care.

In Illinois, only doctors of medicine and osteopathy are licensed under the state's Medical Practice Act to practice medicine in all of its branches. In addition, ISMS policy states that "sick people should receive appropriate care under the direction and supervision" of a fully licensed physician. And although professional health care services provided by "ancillary health professionals play a vital role in care and are encouraged," this care should not be provided "without the direction of a physician," the policy continues.

(Continued on page 17)

Health committee enjoys Republican majority

LEGISLATION: The Senate Public Health and Welfare Committee tackles Medicaid assessments, health care reform and other issues. By Anna Brown

[SPRINGFIELD] Now that the March 10 deadline for introducing new bills has passed, state legislators are spending time in hearings to determine which legislation will make it to the House and Senate floors. In the Illinois Senate, the Public Health and Welfare Committee is working under its new Republican majority, a luxury Senate GOP committee

(Continued on page 18)





State Sens. Dan Cronin and Judy Baar Topinka see a changed legislative health focus under Republican leadership.

ISMS BEHIND THE SCENES

COUNCIL ON EDUCATION AND MANPOWER MONITORS THE MATCH

It's that time of year again. March 17 was Match Day – the day the 1993 candidates for the National Resident Matching Program have been anxiously awaiting. Although the match is completed for candidates, the work of the ISMS Council on Education and Manpower is only beginning. The council mission includes studying and evaluating all phases of medical education and communicating practicing physicians' viewpoints to deans of medical schools, directors of residency training programs and directors of medical education. As part of that mission, the council monitors match results and conveys that information to the ISMS Board of Trustees.

Specifically, the council annually reviews the statistics regarding the number of residency positions offered and filled in Illinois, and the percentage of positions filled in Illinois and nationally. It also compares numbers and percentages according to specialty

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U.S. Surgeon General Antonia Novello, MD, addressed a group of health care professionals at a conference on Hispanic health concerns.

Surgeon general addresses Hispanic health

[CHICAGO] U.S. Surgeon General Antonia C. Novello, MD, visited Chicago to open and lead the regional meeting for the National Hispanic/Latino Health Initiative at the Westin Hotel Chicago March 11 and 12. Ten Midwestern states were represented, including Illinois, Indiana, Kansas, Michigan and Wisconsin. "Our landmark initiative, the first of its kind, has already earned widespread support at the highest national level," Dr. Novello said. "Now we must tailor our national strategies to meet regional and local health needs."

Hispanics form the single largest and youngest ethnic minority in the United States, with more than 22 million people and representing more than 8 percent of the U.S. population. Studies indicate that for this group, the prevalence of diabetes is three times higher than for Caucasian non-Hispanics; the TB rate is almost five times greater than among Caucasians, doubling among Hispanic children in the past few years; and AIDS is now the sixth leading cause of death among Hispanics. "Hispanics are at once the most highly employed minority and the poorest minority living in the United States today," said Dr. Novello.

The conference worked to classify health issues according to access to care, improved health and science professions, migrant health, and improved research methods and data collection strategies. Chicago is one of four regional sites to host a meeting leading to a national workshop scheduled for next fall. ■

CLIA penalty deadline postponed indefinitely

[WASHINGTON] Physicians who failed to register their in-office laboratories with the federal government under the CLIA program are receiving a small reprieve.

HCFA had set March 1 as the date on which it would begin penalizing physicians who did not obtain CLIA registration numbers by refusing to pay Medicare claims for lab tests submitted without the ID numbers. But HCFA has indefinitely postponed setting a new deadline. Physicians were supposed to register by Sept. 1, 1992.

Those doctors who failed to register are not totally off the hook. Although HCFA is temporarily backing away from imposing a deadline, the penalties will be imposed at some point. At that time, the government not only will begin refusing Medicare claims but could also demand repayment of lab reimbursements retroactive to Sept. 1, 1992. In addition, HCFA said it will not commit to providing a warning period before the penalties begin.

For those physicians who wish to continue in-office laboratory testing, ISMS advisers recommend immediate registration to avoid penalties. For more information about CLIA registration and certification, contact the ISMS department of medical services at (312) 782-1654 or (800) 782-ISMS. ■

Counties investigating salmonella outbreak

[SPRINGFIELD] The Illinois Department of Public Health has confirmed 16 cases of salmonella in Cook, DuPage and Lake counties. People infected are believed to have contracted the bacteria on Feb. 14 at four restaurants of a national hotel chain.

County health departments first received word of the outbreak about one week after exposure.

According to IDPH, it takes anywhere from six to 72 hours before symptoms begin to show. If salmonella is suspected, tests are performed and samples sent to the state lab for confirmation. According to IDPH, all those infected in the Valentine's Day incident have fully recovered. County health departments are investigating the outbreak, and all related information is sent to IDPH as it becomes available. ■

Ballpark backs down

[CHICAGO] Wrigley Field will not yet join the growing list of major league ballclubs' stadiums that have gone cold turkey on tobacco. Although the Chicago Cubs have discussed reducing stadium smoking, it will not be banned in any area of the park except the press boxes for the 1993 season.

"We will definitely be actively encouraging people not to smoke," said Mark McGuire, Cubs executive vice president for business operations. McGuire added that the Cubs will "go as far as we can without dragging people out of the park."

According to other Cubs officials, the subject of banning smoking in future seasons has not been tossed out, but McGuire said he was wary of enforcing such a ban.

"We feel that smoking is clearly not a behavior we would like, but there will always be a few people who don't abide [by smoking rules]," McGuire said, explaining that the club did not want to implement a smoking rule and be obligated to enforce it. "We don't want to create a gestapo image," he said.

The Cubs will implement several measures to curb smoking during games, including public address and message board announcements asking patrons not to smoke. Ushers will also carry cards to hand out to fans as they take their seats. "We're expecting a real impact," McGuire said. "Smokers will go along with the requests voluntarily."

On Chicago's South Side, at Comiskey Park smoking is prohibited only in closed concourses and elevator areas. White Sox officials say they have no plans to implement a stadium-wide no-smoking policy. ■

PHYSICIAN FACTS

Reality vs. perception of health care costs

Atlanta-based Medirisk Inc., a health care pricing information company, surveyed 1,057 households in July 1992, asking what the residents believed were the costs of various medical procedures. The results indicate that many Americans do not know how much medical procedures cost.

	Average perception	Actual national average fee
Routine gynecological exam and Pap smear	$ 320	$ 105
Complete physical	$ 270	$ 111
Adult office visit	$ 151	$ 47
Mammogram	$ 315	$ 88
Treating a broken arm	$ 583	$ 418
Vaginal delivery of a baby	$ 2,595	$1,999
C-section delivery	$ 3,661	$2,636
Hysterectomy	$ 3,048	$2,493
Open heart surgery	$12,804	$7,280
Tonsillectomy and adenoidectomy	$ 1,437	$ 726
Well baby checkup	$ 512	$ 42

UIC to build research center

[CHICAGO] The University of Illinois at Chicago will receive $45.9 million from the state to build a molecular biology research center. The construction project will be the largest at UIC since the University of Illinois Hospital was completed in 1980 for $60 million.

"This is a win-win situation for everyone," said Gov. Jim Edgar in announcing the funding. "The economy of the state of Illinois will be helped, both short term and long term by the construction of this building." The UIC expansion will create about 400 jobs, said Edgar, adding that the state and the school will try to award 30 percent of the work to minority companies and 10 percent to businesses owned by women.

Funding was approved by the General Assembly several years ago and will come from a capital spending budget, said Edgar. "This is not general revenue dollars. [The money] had to go for a capital project."

The center will provide modern laboratories for many UIC departments, which should help attract students, faculty, researchers and research funds, said UIC President Stanley Ikenberry. Edgar said he hopes the center will draw businesses that want access to high-tech research.

Advances in molecular biology offer hope for treatment of many diseases, including cancer, and have recently enabled scientists to produce the blood clotting factors lacking in hemophiliacs.

Construction of the research center is scheduled to begin in April and to be completed in early 1995. ■

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Amalgams found safe

[WASHINGTON] The U.S. Public Health Service recently released a study revealing that mercury-containing dental amalgams pose little threat to public health and need not be avoided or removed. The study was undertaken to answer questions about the long-term effects of mercury in fillings.

The study determined that although amalgam fillings release small amounts of mercury vapor, the levels are too small to be considered a health threat to all but a few people who could experience allergic reactions. However, the report states that research should continue to further clarify the possible long-term health risks of amalgams, as well as to find safe alternatives.

PHS will promote the use of fluorides, sealants and other measures to avoid cavities, eliminating the need for fillings. Amalgam manufacturers should also be required to disclose ingredients to dentists to help prevent allergic reactions. ■

California MDs endorse health care budgeting

[ANAHEIM] Straying from traditional physician perspectives, California doctors have endorsed prospective budgeting as a necessary part of health care cost containment. The "unprecedented" show of support for budgeting physician services was made during the California Medical Association's House of Delegates meeting earlier this month.

"We are proud to take this bold step at this pivotal time in health system reform," said CMA President Richard F. Corlin, MD. "It marks a progression in our continuing moves to lead the health system reform effort."

Dr. Corlin stressed that the new CMA policy is linked to budgeting requirements of other segments of the health care system. Such budget negotiations also should occur in concert with comprehensive cost-containment efforts and elimination of access barriers to the nation's uninsured. Prospective budgeting does not set caps or limits on health care expenditures; instead it establishes softer goals and targets for health care spending. It is not global budgeting.

The physician group outlined its continued opposition to "arbitrary fixed limits" on health care spending to hold down costs. Appropriate budgeting must account for "actual increases" in the health care goods and services provided.

The AMA supports the concept of prospective budgeting provided it is flexible. "The entire medical profession favors predictable spending and reductions in health care costs," said Raymond Scalettar, MD, chairman of the AMA Board of Trustees. "However, budget predictability cannot be achieved without input from the medical profession. Fixed budgets do not take into account demographic, disease and technological changes. Any form of budgeting that restricts access or threatens the quality of patient care by establishing bureaucratic limits on health care services is unacceptable."

Illinois physicians have not endorsed prospective budgeting efforts, although the 1992 ISMS House of Delegates did adopt policy stating that nonphysician health care providers should be subject to the same cost containment as physicians. In addition, ISMS' Third Party Payment Processes Committee has discussed concerns about global budgeting.

At the legislative level, the Illinois General Assembly is currently considering several bills that propose global budgeting on the health care system. ISMS opposes those measures. ■

Names changed in Humana division

[CHICAGO] Two Illinois hospitals changed their names recently when parent company Humana Inc. divided into two companies. Nearly 80 hospitals will be managed by the new Galen Health Care Inc., while Humana will offer insurance and managed care plans under the former name.

The two Illinois hospitals affected by the change are Humana Hospital-Michael Reese in Chicago, which will resume the name Michael Reese Hospital and Medical Center, and Humana Hospital in Hoffman Estates, which will be known as Hoffman Estates Medical Center.

"For Michael Reese Hospital and Medical Center, this corporate change will permit us greater flexibility and responsiveness in the Chicago market," said Sam Holtzman, Michael Reese executive director. "The Michael Reese name is known and respected internationally, and we plan to continue the tradition of pioneering research and clinical medicine in Chicago." ■

CORRECTION

In the story "ISMS goes to Washington" in the March 12 issue, U.S. Rep. Donald Manzullo should have been identified as a Republican, not a Democrat.

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REPORT FOR *Illinois Physicians*

NEW FORMAT FOR THE BLUE CROSS AND BLUE SHIELD REPORT FOR ILLINOIS PHYSICIANS

It has long been a goal of Blue Cross and Blue Shield of Illinois (BCBSI) to maintain a very positive relationship with the physicians of this state, and in particular with the members of the Illinois State Medical Society. One of the mechanisms by which BCBSI has hoped to achieve this liaison has been this BCBSI Report for Illinois Physicians -- the so called ***"Blue Sheet"***. Heretofore, the content of the Blue Sheet has often dealt with insurance rules and processes; although these matters are important, they are often of more interest to office personnel than to physicians themselves. In order to develop a ***"Blue Sheet"*** which will have real appeal to physicians, and which would, therefore, enhance their interaction with BCBSI, BCBSI has asked its Medical Department to author every other edition of the ***"Blue Sheet"***. As in the past, the alternating ***"Blue Sheets"*** will be devoted to Medicare issues, and those editions will continue to frequently address Medicare rules and regulations.

As Corporate Medical Director of BCBSI, I would really like to make the ***"Blue Sheet"*** a forum for Illinois physicians. If you have a concern or a topic which you believe would be of general interest to physicians, please write to me to suggest that this problem be addressed in the ***"Blue Sheet"***. Although I cannot promise that all suggested issues will appear in the ***"Blue Sheet"***, I do sincerely want your input. Write to me at:

Arnold L. Widen, M.D.
Corporate Medical Director
Blue Cross and Blue Shield of Illinois
233 N. Michigan Avenue, 15th Floor
Chicago, IL 60601

(Issue: 03/26/93 - BS)

Public health, employee health plan reap budget benefits

GOVERNOR'S BUDGET: Stemming the spread of AIDS and fully funding the state workers' insurance program are among Gov. Jim Edgar's priorities for fiscal 1994. By Tamara Strom

[SPRINGFIELD] Through general revenue funds, the Illinois Department of Public Health stands to receive $3.6 million for its AIDS programs, a doubling of the current funding level.

"General revenue funds are like gold, so this is a very dramatic increase in our budget," said IDPH spokesperson Tom Schafer. "In the past we've fought to get additional money, and we've been happy we haven't been cut. The funding increase is very welcome and very needed."

IDPH's total budget is $412 million, but only $93 million of that is GRF, Schafer said. The rest is federal money. Because the state GRF portion of the budget is so small, "any switch in GRF is significant; it has ripples throughout the whole agency," he said. A few years ago, IDPH received $107 million in GRF, so the current $93 million is a significant drop the department has absorbed, he added.

"The proposed increase will enable us to move forward in some areas and recoup some of the losses we've had," Schafer noted.

Edgar's recommended appropriation for the AIDS budget line was "significantly more" than many advocacy groups had lobbied for. Several AIDS groups met with the governor asking for a $2 million increase for AIDS education and prevention programming, Schafer said. The governor penned $3.6 million in additional GRF to the AIDS line, bringing the total to $7.1 million.

The proposed budget also allows for IDPH to double the number of children it tests for lead poisoning, Schafer said. The $2.9 million budgeted will cover lab testing for 120,000 Illinois children, compared with 60,000 tested in the past.

Although no funding increases were included for the department's immunization and Women, Infants and Children programs, additional money could be forthcoming from the federal government, Schafer said. For example, President Clinton has made reference to a large-scale immunization program and making full funding available for 100 percent of the people eligible for WIC, he said. In the WIC program, this funding influx would mean $100 million in federal monies, boosting Illinois' WIC rolls from 215,000 to 430,000. The department currently serves only 50 percent to 52 percent of WIC-eligible residents.

> *In the past we've fought to get additional money, and we've been happy we haven't been cut. The funding increase is very welcome and very needed.*
>
> **TOM SCHAFER**
> **IDPH SPOKESPERSON**

The local health department line is fully funded under Edgar's proposal, which is "significant," Schafer said, because "local health departments are called on to do so much." The increases have positive funding ramifications for the state's newest local health departments. The departments in Woodford and Washington counties will be fully certified this year, having fulfilled all IDPH's requirements. The Knox County and Jefferson County health departments – approved last year by voter referendum – also will receive grant money to continue their start-up activities.

THE STATE EMPLOYEES' HEALTH PLAN has been a traditional source of frustration for Illinois physicians. The state's fiscal crisis left state government little choice but to underfund the program the last few years, leaving doctors who treat state workers to wait months for payment. The upturn in the state's economy, coupled with Edgar's renewed commitment to fully fund the program, should bode well for physicians this year.

Edgar proposed a GRF increase of $123 million to fully fund the employees' health plan for fiscal '94. With the additional funding, the total recommended appropriation for next year is

(Continued on page 19)



Downstate district jumps into action

COUNTY SOCIETIES: A south-central Illinois trustee has high hopes for renewed membership enthusiasm within his district. By Anna Brown

[DECATUR] Downstate county medical societies are taking an active role in state and national organized medicine as they turn to projects that promote a new image to the community and to members. Seventh District Trustee Ronald L. Ruecker, MD, an internist from Decatur, is at the forefront of the push to build a stronger link between ISMS members in central and southern Illinois rural counties and their local medical societies.


Dr. Ruecker

"The key issue is education and involvement," said Dr. Ruecker. He hopes to see the counties in his district sending more delegates to the state society, holding regular meetings and making their dues work for them.

"The most important benefit provided by medical societies is information," Dr. Ruecker continued. "Many people need to be aware of activities at the state and national level. The best way for some is through the county medical society. If societies aren't meeting regularly, physicians aren't getting information."


Carol Gapsis

District Seven, in south-central Illinois, includes Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt and Shelby counties. The Effingham County Medical Society will meet with ISMS President Arvind K. Goyal, MD, this month. Carol Gapsis, the new Effingham County executive and president of the ISMS Auxiliary, said the meeting should spark enthusiasm in society members. Effingham, Clinton and Marion counties plan to join the Auxiliary's mini-internship program next year.

"We're just at the baby stage," Gapsis said, explaining that Effingham County had faltered in the past because of lack of leadership within the society.

"Frankly, for a long time, counties could survive without taking active measures," Dr. Ruecker said. But the need for information on regulations like CLIA '88 and national issues such as health care reform are forcing counties to be more active.

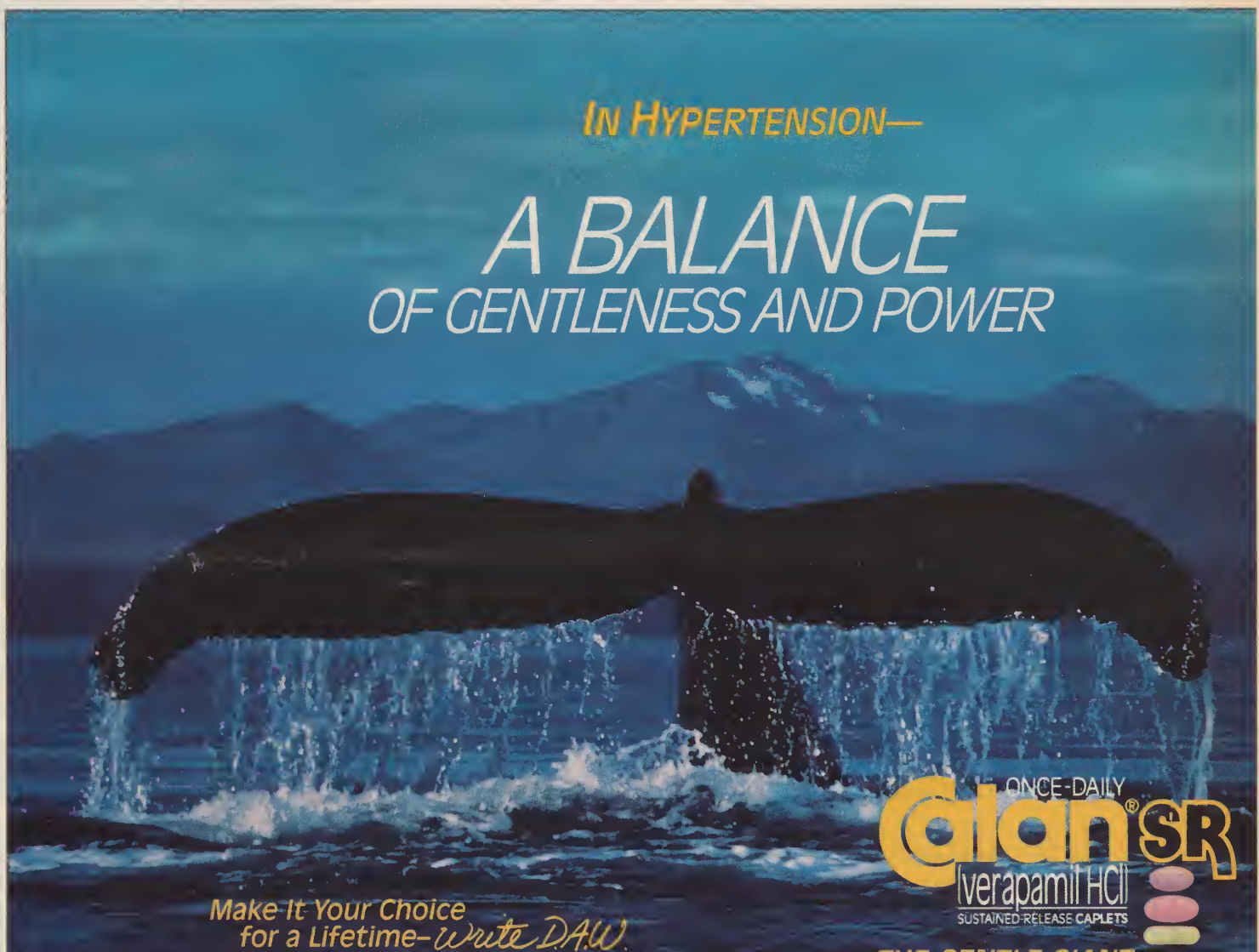
Dr. Ruecker hopes to bring all the counties in the Seventh District together for a meeting within the next year. In the meantime, he is traveling to society meetings within his territory to act as a resource. "Physicians need to take advantage of what membership offers," he said, adding that because he lives and practices in the same region, he can better understand their concerns. "My job is to help spread the word of ISMS and get people involved at the grass-roots level."

Another goal for Dr. Ruecker is to develop a core group of leaders to represent the counties at the state level. Once this is established, he said, the process will continue. He explained that lack of involvement is one of medicine's biggest problems, even nationally.

"Physicians don't have the luxury of ignoring the environment in which they are forced to practice," he said. "One person can make a difference, and rewards come in the satisfaction of leaving something for the next generation." ■

District Seven





The recommended starting dosage for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food. Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk, therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia, HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

Celebrating Doctor's Day

At a time when cost and paperwork hassles are infringing on the physician-patient relationship, it's more important than ever for doctors and patients to work together to preserve their vital partnership. Doctor's Day, on Tuesday, March 30, is an occasion to celebrate the physician-patient partnership and doctors' achievements.

Congress declared an official observance of National Doctor's Day in 1958 to commemorate the first use of ether anesthesia for surgery by Crawford Long, MD, in 1842. In 1991, President Bush declared March 30 National Doctor's Day in honor of American physicians, marking its elevation to official presidential proclamation status.

The proclamation states: "In addition to the doctors whose names we easily recognize, there are countless others who carry on the quiet work of healing each day in communities throughout the United States. Common to the experience of each of them, from the specialist in research to the general practitioner, are hard work, stress and sacrifice. All those Americans who serve as licensed physicians have engaged in years of study and training, often at great financial cost. Most endure long and unpredictable hours, and many must cope with the conflicting demands of work and family life."

Although the demands themselves have changed, their existence over the past 100-plus years has not. Back in 1877, when the Illinois Department of Public Health was established, the only requirement for becoming a doctor was hanging out a shingle. That year, the first workable law was passed to regulate the practice of medicine, and the first lectures on bacteriology were delivered.

In case such minimal regulation makes you yearn for the good old days, consider the "clinical" drawbacks of that time. Physicians traveled long and far by train, horse and buggy, or bicycle to see patients in the patients' own far-from-sterile homes. They treated patients for a variety of ailments, from the simple to the complex, with only minimal healing tools at their disposal. Payment was often made not by cash but by bartering produce in exchange for care.

Today, over-regulation and hassles have accompanied the welcome high-tech advances that facilitate better patient care. However, now, as in the past, the patient-physician relationship is at the heart of superior patient care. Patients are actively participating in their health care and are interested in prevention. They're trying to stop smoking, to eat a healthy diet and to exercise.

And doctors are learning the importance of increased patient communication. They're asking more questions, and explaining procedures, medical terms and drug interactions in more detail.

During these challenging times of scrutiny about what's wrong with health care, it's a relief to celebrate what's right about it.

PRESIDENT'S LETTER

A little nothing here will get us nowhere at all: no reform without tort reform

By Arvind K. Goyal, MD



The good, the careful, the compassionate, the skilled, the intense and the obsessive amongst us are as much at risk as the rest.

A grocer, while delivering orders in a station wagon, skidded and injured a young lady on the street. The lady got well, but sued anyhow, and was awarded an amount large enough to drive the man out of business. After difficult times he managed to accumulate enough to try again. A few months after reopening his business he struck an old customer in an accident with his delivery truck. He got sued again and had to pay out big damages, enough to ruin him. On a peaceful Sunday, the grocer was sitting in his living room when his little boy ran in calling out, "Daddy, Mother's been run over by a great big bus." The grocer's eyes filled with tears, and in a voice choking with emotion, he cried, "Thank the Lord, our luck's changed at last."

Many of us would identify easily with that grocer, for there are only a few practicing physicians left who have never been sued. The good, the careful, the compassionate, the skilled, the intense and the obsessive amongst us are as much at risk as the rest – for malpractice, like cancer, diabetes and AIDS, knows no boundaries.

"Consider every patient walking through your office as a potential plaintiff" was the message delivered at a recent CME course I attended. I didn't like what I heard, but I understood. You never know! The patient who thanked me the loudest, the one who referred to me many others in his family, the one who brought tomatoes from his farm last Saturday, the one who invited me for dinner at his home, or the unemployed patient I never charged could be the one suing me tomorrow. Not because I did anything wrong, negligent or less caring, but because things didn't go the way my patient expected, the recovery was a little slower, the neighbor's scar was a little smaller, or an attorney sought out and convinced my patient I could be had. It may sound foolish not to buy a lottery ticket when somebody tells you one out of four tickets bought is going to win big, with an average expected payout being $336,000 today compared to $86,000 a decade ago! And there is no penalty for losing, since it is all on a contingency basis. A windfall settlement made under duress of litigation – in consideration of my lost practice time, defense attorney fees, cumulative stress becoming unbearable for me and my family, and unquantifiable losses attributed to publicity that goes with the territory – or an outright outrageous award a few years down the road could change my patient's life forever – and mine too!

Patients of physicians in certain specialties and in some Illinois counties pay $80,000 to $100,000 a year today for claims-made insurance coverage. Malpractice premiums alone add $250 to the cost of delivering one baby in Illinois! And then there are wasted health care dollars – defensive medicine – spent because physicians are under the gun. They can ill afford to take a chance! So, very expensive tests and treatments are ordered – that is what fear, the demon of malpractice, makes them do! So an MRI scan is ordered for every headache and head injury patient, an OB ultrasound is done on each prenatal visit, and a cesarean section delivery is scheduled for the littlest reasons. Such situations defy logic and blur the lines between a good and a "mad" medical practice, between a reasonable treatment plan vs. a hysterical race to prevent a lawsuit at any rate.

Most reasonable people would advocate and support quick, fair and undivided compensation to a patient wronged or injured by medical malpractice, to include all tangible and predictable losses including medical expenses, lost wages and other living expenses. But the proposed losses that never occurred – compensation for pain, suffering and loss of consortium – do not make sense! A recent award of $127 million levied against a drug company doing business in Illinois included $3 million for economic damages and $124 million for noneconomic purposes! My pain and suffering have never been worth anything. And my spouse would settle for a lot less for me not sleeping at home for a whole month! Those built-in abuses in our legal system need to be fixed quickly. A reasonable ceiling, a "cap," on such noneconomic damages would be a logical start.

As the newest comers to Washington, the Clintons, ponder over the various possibilities in reforming our nation's health care system, many, including physicians, hope that tort reform will be an integral part of their plan to save costs, prevent waste and improve access to health care. That would have to be, if their commitment to a meaningful health care reform is sincere. Failing action in Washington, a well-prepared initiative in Springfield may be our only choice, and that may be "doable." That is, if we all do our homework, cover the bases with our patients, and educate our legislators and others starting today!



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GUEST EDITORIAL

Physicians speak out in Washington

By Raymond Scalettar, MD

The strong and determined voice of medicine was heard in Washington this week as physicians from Illinois and the rest of the country delivered their message on health system reform to the administration and Congress.

Nearly 1,000 physicians spent three days – March 23-25 – telling the country's top policymakers and Congressional leaders that organized medicine supports total system reform that puts our patients first.

We succeeded in getting our voice heard, thanks to the support of the Illinois State Medical Society and the many member physicians who made the trip to Washington.

The AMA, though it never asked for a seat on Mrs. Clinton's Cabinet-level health care task force, has acquired exceptional access to the president's top policy advisers and the task force's working groups, and they have asked us for our input.

This is what we are telling them:

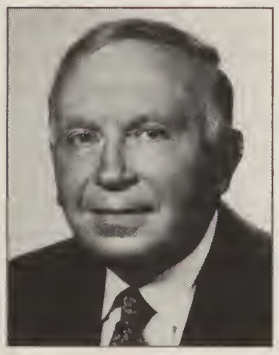
• Without the input of medicine, they will never be able to devise a health care system that works.

• Strict global budgets and price controls are unwise, unworkable and contrary to the best interests of both our patients and our profession.

• We do support predictable spending that considers demographics, disease, technology and the increasing costs of goods and services.

• We also support those aspects of managed care and managed competition that give patients the freedom to choose their own physicians and give physicians access to managed care plans, so long as they meet the criteria.

• Physicians must have the ability to negotiate Medicare changes and managed care systems, as well as the freedom to set and enforce our own self-regulatory standards.



Dr. Scalettar *is chairman of the Board of Trustees of the American Medical Association.*

The decisions being made in Washington this spring will affect the practice of medicine and the lives of our patients well into the next century.

The issues are complex, and the stakes are enormous. I look forward to giving you an update when I join you next month in Oak Brook.

Mark your calendars – ISMS annual meeting set for April 23

The 1993 annual meeting of the ISMS House of Delegates will be held Friday, April 23, through Sunday, April 25, at the Oak Brook Hills Hotel. The opening session of the House will begin at 9:30 a.m. on Friday, followed by district meetings. At Reference Committee A, on Friday at 1 p.m., a special presentation will be made regarding ISMS financial reports; all other reference committees will meet at 1:30 p.m.

The Medical Student Section will meet Saturday, April 24, at 11:30 a.m., and at 3:30 p.m. a seminar will be held regarding health care reform and related national activity. All ISMS members are encouraged to attend this seminar. For more information on any annual meeting events, call ISMS at (312) 782-1654 or (800) 782-ISMS. ■

GUEST EDITORIAL

Coping with the stress of litigation

By James P. Ahstrom Jr., MD

Dealing with medical malpractice lawsuits has become a part of almost every physician's life. Sixty percent of the doctors now practicing have been sued, and the rest may soon follow. This does not mean that physicians are being sued because they are bad doctors. Quite to the contrary, they are often the best doctors, the ones who deal with the most complicated problems and take care of patients with the highest risks and most difficult medical challenges.

In 1992, the Illinois State Medical Inter-Insurance Exchange received 2,339 claims against its policyholders. History tells us that 3 percent of these might go to trial. Of the claims against Exchange policyholders, 81.4 percent are settled without indemnity payment – the national average being 67.5 percent. Of those that do go to trial, 75 percent are resolved in the physician's favor.

In spite of these figures that favor physicians, there is still an appreciable problem when the summons arrives. Physicians experience emotions similar to those experienced by the bereaved. Fear or panic are soon replaced by anger. Doctors have difficulty believing that their best efforts have been rewarded by a lawsuit. They feel betrayed by their friend and patient for whom they have done their very best. They may begin to doubt their decisions about the patient's care and to question their judgment for future patients. Finally, they accept the situation and feel depressed when they fully realize what has occurred and that their professional existence is in jeopardy.

During the time between the summons and the disposition of the action, which can be many years, there are conferences with attorneys and depositions taken. At these times, when legal activity heats up, the same chain of emotional reactions may occur. Consequently, during any single liability action, physicians may experience many stresses many times. Physician reactions can be profound. Many have stopped practicing medicine, while others have drastically changed their scope of practice or their approach to their patients' problems.

Sara Charles, MD, of the University of Illinois, has conducted much research on the effect of liability actions on physicians. Through her efforts, the Exchange's Physician Support Group was formed. The group consists of interested physicians and their spouses who are ready and willing to provide moral support to Exchange policyholders involved in litigation. Since September 1991, the group has sponsored the seminar "Taking Control: Managing Your Malpractice Lawsuit" quarterly. Seminar panelists include an attorney, an Exchange professional liability supervisor and a physician.

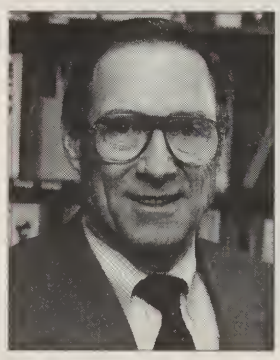
Because much of physicians' anxiety arises from unfamiliarity with the legal process, the attorney describes the process and pitfalls, and a liability supervisor explains the insurance company's role. Defendant physicians have to be so familiar with the case that they can practically recite the records verbatim, and they must be authorities on the medical aspects.

> *Physicians should regard their preparation as similar to studying for a board examination. After all, doctors are the real authorities on the case, and they must properly advise their attorneys.*

Physicians should regard their preparation as similar to studying for a board examination. After all, doctors are the real authorities on the case, and they must properly advise their attorneys. Through preparation, doctors gain confidence and can deal with the onslaught from plaintiffs' attorneys. Testifying, of course, must be done in a calm, authoritative manner devoid of any arrogance, haughtiness or impression of superiority.

During the dragged-out machinations of discovery and litigation, physicians must learn to deal with their fear, anxiety, depression and anger. Different individuals do this in different ways. It helps to participate in hobbies or sports in which they are proficient. Developing intellectually and culturally by studying other fields such as music, art or religion is most beneficial. In other words, physicians must reinforce and bolster their self-esteem to cope with the merciless and ruthless attack that may be impending because of the plaintiff's suit.

The most important assurance for defendant physicians is their knowledge that they have done their very best.



Dr. Ahstrom *is an orthopedic and hand surgeon in Downers Grove and chairman of the Physician Support Group.*

For information about writing a guest editorial for Illinois Medicine, *call (312) 782-1654 or (800) 782-ISMS.*

March employee of the month takes pride in her work

She had a dream in which she was named ISMS Employee of the Month; one week later she was accepting the award for real. Linda Malleck, March Employee of the Month, said from now on she will pay more attention to her dreams.

Bud Gross, ISMS vice president of finance, said he never imagined he would be presenting an Employee of the Month award, because the work of the finance department may not be perceived as a service. Often, the finance department's only contacts with physicians are through routine tasks such as providing 1099 forms. "But now, I am a believer that the work of finance can be done in a service mode," Gross said. In presenting Malleck with the award Gross said her nominator cited her professionalism and said she has always been a supportive team player who takes pride in her work.

Malleck joined ISMS in April 1989 as an accounts payable clerk and was promoted to accounts payable accountant three years later. She spends much of her time on the claims invoice tracking system and frequently communicates with attorneys and consultants to justify billings. A lawyer who works with Malleck said ISMS is lucky to have an employee like her. In accepting her award, Malleck thanked her nominator for the recognition. "It is always great to receive recognition," said Malleck, "and standing in front of my peers to accept this award is super."

All permanent, full-time ISMS and ISMIS employees, with the exception of senior management, are eligible for the Employee of the Month award. To nominate a staff member, contact the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■



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Bud Gross, ISMS vice president of finance, congratulates March Employee of the Month Linda Malleck.

BECAUSE APPROXIMATELY 60% OF PATIENTS WITH PERSISTENT ANXIETY MAY EXHIBIT DEPRESSIVE SYMPTOMS...[1]

BuSpar® 10mg

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Now indicated for the relief of persistent anxiety with coexisting depressive symptoms.*

- Anxiolytic efficacy demonstrated in anxious patients with or without coexisting depressive symptoms.[2]
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- Nonaddictive, no more sedation (10%) than seen with placebo (9%).[4,5]
- The more commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%).

Progressive Relief of Persistent Anxiety.

*BuSpar is not indicated for the relief of primary depressive disorder.

Please see references and brief summary on adjacent page.

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BuSpar® (buspirone HCl)

References: 1. Data on file, Bristol-Myers Squibb Company. **2.** Cohn JB, Bowden CL, Fisher JG, Rodos JJ. Double-blind comparison of buspirone and clorazepate in anxious outpatients with or without depressive symptoms. *Psychopathology.* 1992;25:10-21. **3.** Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multistudy, double-blind evaluation of buspirone. *Neuropsychobiology.* 1989;21:124-130. **4.** Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med.* 1987;82(suppl 5A):20-26. **5.** Newton RE, Marunycz JD, Alderdice MT, Napoliello MJ. Review of the side-effect profile of buspirone. *Am J Med.* 1986;80(suppl 3B):17-21.

Contraindications: Hypersensitivity to buspirone hydrochloride.

Warnings: The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

Precautions: ***General*** – *Interference with cognitive and motor performance:* Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable; therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients: Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdraw patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

Possible concerns related to buspirone's binding to dopamine receptors: Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

Information for Patients – Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding; and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

Drug Interactions – Concomitant use with other CNS active drugs should be approached with caution (see **Warnings**). Concomitant use with trazodone may have caused 3- to 6-fold elevations of SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

Carcinogenesis, Mutagenesis, Impairment of Fertility – No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

Pregnancy: Teratogenic Effects – Pregnancy Category B: Should be used during pregnancy only if clearly needed.

Nursing Mothers – Administration to nursing women should be avoided if clinically possible.

Pediatric Use – The safety and effectiveness have not been determined in individuals below 18 years of age.

Use in the Elderly – No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

Use in Patients with Impaired Hepatic or Renal Function – Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

Adverse Reactions (See also Precautions): ***Commonly Observed*** – The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

Associated with Discontinuation of Treatment – The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

Incidence in Controlled Clinical Trials – Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: *Cardiovascular:* Tachycardia/palpitations 1%. *CNS:* Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. *EENT:* Blurred vision 2%. *Gastrointestinal:* Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. *Musculoskeletal:* Musculoskeletal aches/pains 1%. *Neurological:* Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. *Skin:* Skin rash 1%. *Miscellaneous:* Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

Other Events Observed During the Entire Premarketing Evaluation – The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. *Cardiovascular* – frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. *Central Nervous System* – frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. *EENT* – frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. *Endocrine* – rare: galactorrhea, thyroid abnormality. *Gastrointestinal* – infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. *Genitourinary* – infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. *Musculoskeletal* – infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. *Neurological* – infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. *Respiratory* – infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. *Sexual Function* – infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. *Skin* – infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. *Clinical Laboratory* – infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. *Miscellaneous* – infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

Postintroduction Clinical Experience – Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

Drug Abuse and Dependence: ***Controlled Substance Class*** – Not a controlled substance.

Physical and Psychological Dependence – Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

Overdosage: ***Signs and Symptoms*** – At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

Recommended Overdosage Treatment – General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

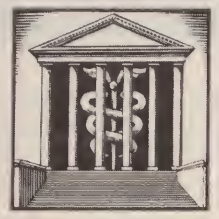
For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

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Malpractice Roundup

PAGE 10

ISMIE Update

Electronic messaging to enhance service

PAGE 11

Working out the hidden kinks in physician employment agreements

The Exchange offers a service to help policyholders deal with the sometimes difficult issues involved in physician employment agreements.

By Gina Kimmey

When a physician enters into an employment agreement, issues can arise, which, if not addressed up front, can lead to problems. One such issue is determining who will pay for the physician's professional liability insurance. Should the contracting group or the physician pay? And if the group pays, what will happen to the premium if the group and the physician part ways?

MANY CONTRACTING groups choose to pay for their physician's insurance coverage. In this case, both parties should understand and agree on the procedure if the employment relationship is terminated. Will the physician continue the policy independently, or will the physician terminate the policy, and if so, who will receive the refund from the unused premium?

The Exchange strongly encourages policyholders to clearly establish such issues at the time of employment and to document the agreement.

> *We want to provide our policyholders with the best possible service, which means adapting to different needs.*
>
> **HAROLD L. JENSEN, MD**

To assist in this task, the Exchange offers its policyholders a "release of premium" form.

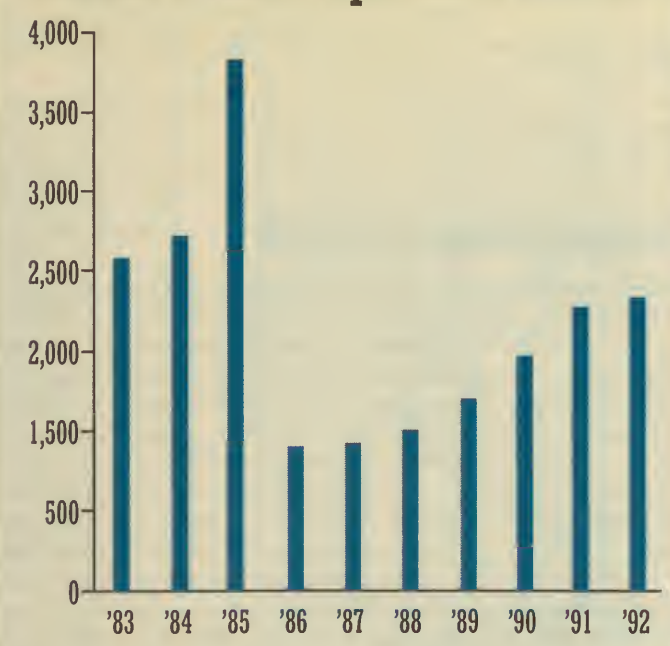
"The Exchange recognizes that a great number of physicians are involved in employment agreements," said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. "We want to provide our policyholders with the best possible service, which means adapting to different needs, whether the setting is a clinic, hospital or group practice."

EXCEPT IN THE CASE OF the Exchange's group/clinic policy, which is owned by the group, if the employment relationship is terminated, the policy remains in the physician's name and is technically owned by the physician. By signing a release of premium, both parties agree on who will receive the remaining premium refund if the employment relationship terminates. The form should be signed when the group agrees to pay the insurance premium for the physician. Without such an agreement, the unused portion would be refunded to the physician as owner of the policy. Any other arrangements would need to be made between the entity and the physician.

"The release of premium form will clearly state the conditions of the group-provided insurance coverage and will ensure that the policyholder receives whatever refund is due hassle-free," said Dr. Jensen. "This is an example of ISMIE's continuous efforts not only to meet its policyholders' immediate needs, but to help prevent problems they may encounter down the road."

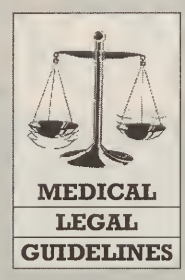
Exchange policyholders may obtain copies of the release of premium form by calling the Exchange underwriting division at (312) 782-2749 or (800) 782-ISMS. ■

ISMIE claims reported 1983-92



1985 claims surged due to plaintiff attorneys' filing of claims to evade tort reform measures.
Source: Illinois State Medical Inter-Insurance Exchange

Legal directives explained



DNR orders are physicians' orders that no resuscitation measures should be initiated on behalf of a patient who experiences cardiac or respiratory arrest. A DNR order policy should set forth the circumstances and document the procedures to be followed when physician members of the medical staff issue a DNR order. Physicians should ask their patients why they wish to avoid emergency CPR and record the patient's reasons in the medical record. However, physicians are under no obligation to write a DNR order for their patients. If a physician considers it inappropriate, he or she must promptly advise the patient of this unwillingness, take all reasonable and appropriate steps to help transfer the patient, deliver medical records to the care of another physician, and provide reasonably necessary consultation and care in connection with the transfer. Specifics can be obtained from the ISMS brochure "Guidelines for Writing Do Not Resuscitate Orders."

FOR DUE PROCESS guidelines, follow the ISMS brochure "Due Process Guidelines For Physicians." The brochure is a guide to help physicians protect their constitutional rights to substantive and procedural due process when medical staff appointments or privileges are at risk. Moreover, it suggests due process provisions that can be incorporated into bylaws, contracts or agreements used by other health care facilities, county medical societies, large group practices or any entity offering a peer review process to handle disciplinary matters or complaints.

THROUGH A DURABLE power of attorney for health care, whereby an individual authorizes another person to make all health care decisions in the event the patient becomes disabled and unable to direct the management of his or her health care. The right to designate such an "agent" is given by the Powers of Attorney for Health Care Law [755 ILCS 45/4-1 et seq. (1992)], formerly [Ill. Rev. Stat. 1991, ch. 110 1/2, pars. 804-1 - 804-12], passed by the Illinois General Assembly in 1987.

Individuals may choose to execute either a living will or a DPA or both documents. A living will generally indicates what the patient's decisions are or would be in the event of a terminal illness, while the DPA authorizes the agent to act as the patient would in managing his or her health care. When an individual has executed both declarations, the DPA takes precedence if the agent is available. In the absence of a living will and a DPA, the Illinois legislature established guidelines in the Health Care Surrogate Act that determine when it is appropriate to refuse life-sustaining care.

More information on advance directives is provided in reference guidelines on living wills and surrogates, which discuss the Illinois Living Will Act [755 ILCS 35/1 et seq. (1992)], formerly [Ill. Rev. Stat. 1991, ch. 110 1/2, pars. 701 - 710], and the Illinois Health Care Surrogate Act [755 ILCS 40/1 et seq. (1992)] formerly [Ill. Rev. Stat. 1991, ch. 110 1/2, pars. 851-1 - 851-55] respectively.

Specifics as to the physician's responsibilities under the Powers of Attorney for Health Care Law can be obtained from the ISMS kit A Physician's Guide to Advance Directives, includ-

(Continued on page 11)

MALPRACTICE ROUNDUP

Managed care settings may add malpractice risks

According to The Doctor's Company, a nationwide physician-owned insurance company based in California, managed care can create malpractice risks for doctors. It suggests ways to reduce the risk in three main areas: eligibility, emergency care and utilization review. In managed care, a physician's office staff must respond to the patient's medical problem and initiate prompt medical care, even if the patient's name is not on the monthly eligibility list. Patients who are not on the list and refuse care because of financial concerns should be referred to a free clinic or county hospital, avoiding delay or denial of care.

In an "emergency" situation, managed care requires primary care physicians to authorize treatment before the insurance company will pay. If the visit does not require emergency care, physicians should personally communicate the decision to the patient and explain why they cannot – instead of will not – authorize the visit. Physicians should make it clear that they are acting on insurance company guidelines and that authorization determines only whether the insurance company will or will not pay. The patient is still entitled to care but must accept possible responsibility for the bill.

The utilization review process, as well as the need for referrals, should be clearly explained to the patient. When a referral is not approved, physicians should personally explain why. If physicians suspect that denial of care could jeopardize the patient, they should do everything possible to have the decision reversed.

By establishing policies and procedures to address potential risks in managed care, physicians can greatly reduce the threat of malpractice actions. ■

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

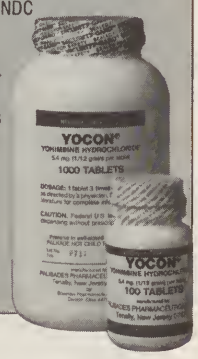
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Eliminating defensive medicine could save $36 billion

According to a study conducted by Lewin-VHI Inc., eliminating defensive medicine could save the U.S. health care system nearly $36 billion over five years. As reported in *National Underwriter*, the study defines defensive medicine as care that may not benefit the patient and is provided mostly to defend or avoid malpractice claims. Lewin-VHI President Robert J. Rubin said one of the purposes of the study was to get a solid estimate of defensive medicine's impact on health care costs. Estimates of such costs vary widely because there is little agreement on how to define the issues. But Rubin identified three specific areas – pre-surgical testing, unnecessary fetal monitoring and skull x-rays ordered in emergency situations – that strongly suggest that defensive medicine is practiced and carries substantial costs.

The Washington-based National Medical Liability Reform Coalition said steps to eliminate defensive medicine – as well as enactment of tort reform and development of guidelines to insulate physicians from liability – should be part of any health care reform. Rubin also pointed out that $36 billion is a midrange estimate and the actual savings could be anywhere from $7.5 billion to $76.2 billion. ■

Doctors sue breast implant makers

As reported in *USA Today*, two Houston surgeons have filed suit against the makers of silicone gel breast implants claiming the product's potential health threat was deliberately concealed. The surgeons claim that if they had known about tests that raised serious questions about the product's safety, they would not have used the implants for cosmetic breast surgery. The physicians seek money from 11 implant makers for damage to their reputations and for lawyers' fees to handle suits filed by women who say they became ill after surgery. The surgeons' attorney said at least a dozen more physicians will join the suit. ■

Malpractice stress syndrome

The impact of malpractice suits on physicians and their families is called the malpractice stress syndrome. Although responses vary, physicians who are sued tend to perceive the suit as an assault on their personal and professional integrity. According to the *Loss Prevention Letter*, a publication for practice and liability consultants, symptoms of MSS include isolation, negative self-image, anger, depression, difficulty in concentration, reduction of appetite and other manifestations of fatigue.

The newsletter offers several suggestions to help physicians successfully cope with stress. They should try to distance themselves from the suit emotionally and not dwell on the "ego insult." It is crucial that physicians use avenues of support aside from their family, especially medical colleagues. The newsletter also suggests physicians list examples of their conscientiousness, competence and compassion, and affirm their positive qualities.

The newsletter stresses the importance of reducing the emotional consequences of litigation stress and mentions several organizations that have developed outstanding models of litigation-stress support groups including ISMIE, the South Carolina Medical Association and the Medical Society of New Jersey.

The ISMIE Physician Support Group can be reached by calling the Exchange at (312) 782-2749 or (800) 782-ISMS.

Editor's note: See guest editorial, page 7, for more information. ■

Supreme Court rejects wrongful birth suit

As reported by United Press International, a Georgia couple cannot sue the United States for "wrongful birth" after an Army doctor misdiagnosed the woman's pregnancy until it was too late to obtain an abortion. The woman first went to the Army clinic complaining of pregnancy-like symptoms, but was assured she was beginning menopause and not pregnant. Four months later, during her third trip to the clinic, she was diagnosed as being five months pregnant. By that point it was too late for the couple to act on the results of an amniocentesis test, which would have shown a malformed fetus. The baby was born mentally retarded and with severe physical defects.

The couple sued the United States under the Federal Tort Claims Act, contending that the woman's constitutional right to have an abortion was violated and claiming "wrongful birth." They argued that if it had not been for the treatment and advice provided by the doctor, they would have aborted the fetus.

A federal district court in Georgia found that because the federal government can be sued under the FTCA only when a private person would be liable under corresponding state law – and Georgia has no law against wrongful birth – the suit could not proceed. The 11th U.S. Circuit Court of Appeals and the Supreme Court upheld the decision. ■

Electronic messaging to enhance service

COMMUNICATION: A new Exchange and ISMS telephone service will save time for physicians. By Anna Brown

[CHICAGO] A new electronic messaging program is the next installment in the push for service improvement within ISMS and ISMIE. Physicians who call the Society or the Exchange will now have the opportunity to leave detailed messages on the system or speak to a staff member immediately.

"The new message service will enhance communication for policyholders without compromising the physician's right to immediate attention," said Harold L. Jensen, MD, chairman of the Exchange Board of Governors.

An advantage of electronic messaging is that policyholders may leave detailed messages when a particular underwriter or claims analyst is unavailable, Dr. Jensen said. In the past, secretaries would note names and telephone numbers of callers, and staffers would return the calls without knowing the policyholder's question. Underwriters and professional liability analysts will receive messages immediately to ensure that calls are returned promptly.

"The system was installed to make calling the Exchange and ISMS more convenient," Dr. Jensen continued. "The more detailed the message, the more efficient the system will be. However, every caller will always have the option of talking to someone right away."

Policyholders will find the electronic messaging system convenient for a variety of underwriting and claims questions and problems. Many underwriting questions require detailed discussion between the underwriter and the physician. Questions regarding the application process, billing dates and cancellations can be answered promptly after the underwriter receives a message. Detailed messages will assist the underwriting and claims departments in handling calls more efficiently. For claims calls, physicians should feel comfortable leaving detailed questions about their cases and can feel confident that only their analysts will have access to the message. When reporting losses, policyholders can leave all pertinent information, and an analyst will contact them for clarifications.

Physicians who enter the electronic messaging system but do not wish to leave messages need only press zero when the message begins. This will forward the caller to a secretary.

"Physicians will continue to receive personal and comprehensive assistance when calling the Exchange," Dr. Jensen said. "The new system is intended to be more efficient and convenient for callers. The Exchange's renewed commitment to service continues to put the policyholder first; minimizing hassles through improved communication leads to improved service and customer satisfaction." ■

Legal guidelines

(Continued from page 9)

ing the brochures "Powers of Attorney for Health Care" and "A Personal Decision." The kit presents information in a question-and-answer format and should be used as a reference piece for physicians. "A Personal Decision" contains materials for the patient or consumer and should be used as a reference piece for such an audience.

HOSPITAL PATIENT TRANSFER GUIDELINES for people who present themselves at emergency rooms are governed by Section 1867 of the Social Security Act, which bars transfer of patients in an unstable condition or in active labor. The Act requires that a hospital with an emergency department provide for an appropriate medical screening examination to determine whether an emergency medical condition exists or whether the individual is in active labor. Subsequently, the hospital must either provide for further examination and treatment or make the appropriate transfer at the request of the patient (or legally responsible person acting in his or her behalf) or at the direction of the physician (or other qualified medical personnel). In the case of a transfer, the receiving hospital must agree to accept the patient, and have both the space and qualified personnel needed. Other types of transfers, including transfers to and from nursing home facilities, are governed by certain standards. In other words, there are provisions on patient transfer in the Illinois Emergency Medical Care and Trauma Codes. Both federal and state legislation/regulations regarding this topic are in a state of flux and will be outlined when final.

The general guidelines for terminating a physician-patient relationship apply regardless of whether the physician will be paid for services. (See guidelines under abandonment, previously published.) The physician should document the steps taken to transfer a patient in the patient's medical record. ■

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BY RACHE

Historically, finding significant numbers of minority students on U.S. medical school campuses was about as easy as finding a needle in a haystack.

But medical schools today have taken notice and have begun offering programs for grammar and high school students who might not have been exposed to medicine but might consider the doctor career path.

The programs are meeting a need. An AMA study revealed that only 10.5 percent of the total 1991-92 medical school enrollment included African-Americans, Mexican-Americans, American Indians and mainland Puerto Ricans. Last year, only 1,815 of the 17,027 first-year medical students came from these racial and ethnic backgrounds, according to the American Association of Medical Colleges.

Because of these inequities, the AAMC has issued a challenge to the country's 126 medical schools: Increase the minority enrollment to 3,000 new students annually by the year 2000.

Even though increasing the number of minorities has always been important to AAMC, the program, Project 3000 by 2000, is taking a new approach by enlisting the help of medical schools. Program director Timothy Ready, PhD, and other experts on minority student enrollment agree that medical schools are responsible for soliciting help from their communities and local school systems in battling this problem.

"We must realize that we cannot correct the problem by ourselves," said Dr. Ready. Project 3000 calls on medical schools to develop science-educational partnerships and provide educational and instructional support for local school systems, said Dr. Ready. This support would include, for example, providing access to medical school professors, sharing laboratories and equipment, and coordinating college and medical school curricula.

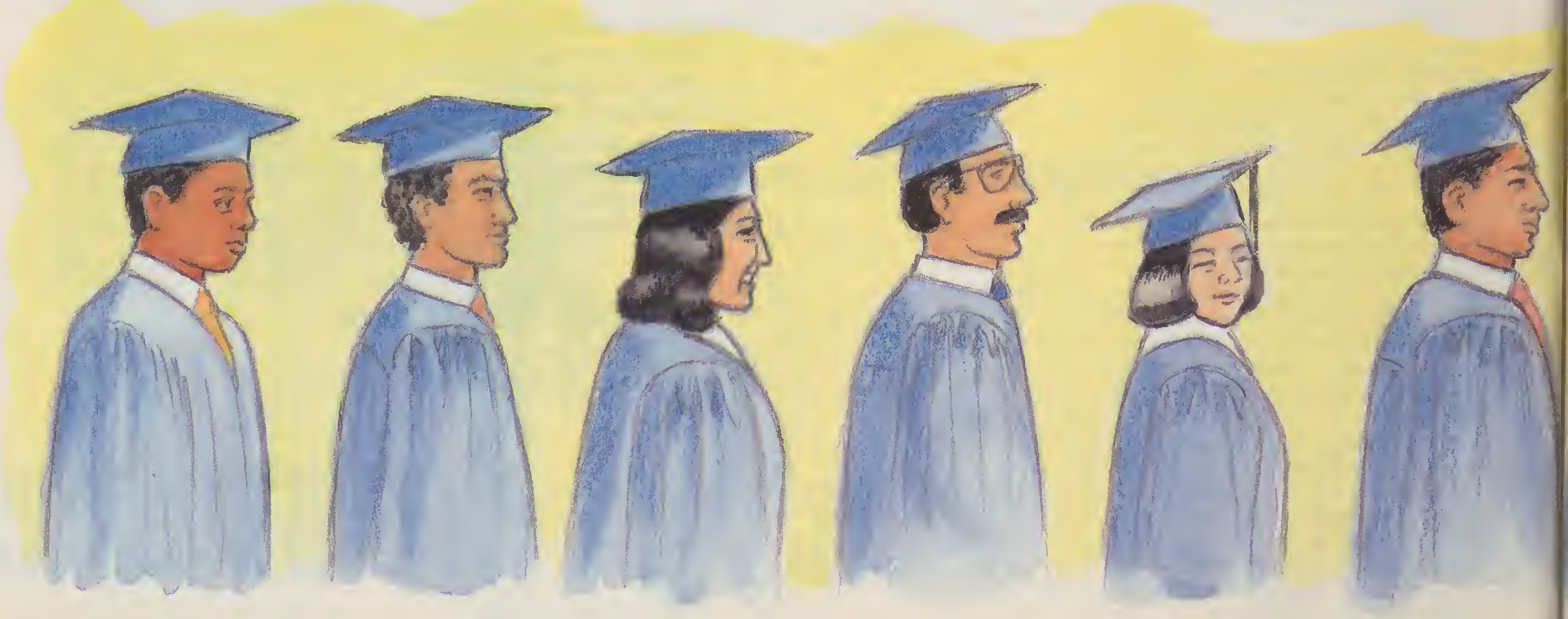
Locally, such programs are already in place. For the past 13 years, the Chicago Area Health and Medical Careers Program (CHAMPS) has offered intensive summer educational sessions to minority students, giving them the chance to explore careers in medicine and the health sciences, said Reggie Jones, PhD, CHAMPS' executive director.

CHAMPS networks with Chicago-area elementary schools and high schools, which in turn "[send] us four or five [children] who are good students and highly motivated, and have all the things that make a little person grow up to be a good doctor," said Dr. Jones.

As early as in the sixth grade, students begin their introduction to medicine through four-week summer sessions with first-year medical students, said Dr. Jones. The medical students, all CHAMPS veterans, teach the children how to perform medical experiments and explain difficult medical terminology.

CHAMPS' unique and personalized approach has been very successful: The program has increased from 100 students in 1980 to more than 1,600 today. In addition, Dr. Jones noted, 40 percent of the minority students who begin the program in sixth grade stay with it through their sophomore year in college. Of those, he added, more than half go on to medical school.

Four years ago the CHAMPS program was expanded to include seven Chicago-area medical schools and focus on college-age minority students who



NIC DIVERSITY

ach for minority students

elical schools are leading the way to increase
rority physicians.

L BROWN

have already decided to attend medical school. The students attend intensive six-week medical school preparatory courses and activities, said Dr. Jones.

THE UIC COLLEGE OF MEDICINE is a "leader in minority student enrollment and graduation in this country," with a 21-percent minority student body, according to Dr. Ready.

William D. Wallace, PhD, associate dean of academic affairs at UIC, attributes UIC's high-minority student enrollment success to a strong university mission and the complete support of the university's chancellor, president and faculty.

"I have worked at two other institutions, and the question there was, 'Will we have any [minority students] represented?'" said Dr. Wallace. "The only question here is, 'How many will we have?'"

Long before Project 3000 by 2000 began, said Dr. Wallace, UIC recruited minority students through early mentor programs with junior and senior high schools, out-of-state recruitment programs and medical students working through community outreach programs.

Carletta Hill participated in the UIC program as a high school student, which gave her the chance to familiarize herself with the campus, meet the professors and get a "sense of how things work in college." Hill, now a third-year medical student at UIC, believes the program was a "nurturing experience" and made her feel more comfortable with medical school. "If you go to a large majority college, it is rare that you got that kind of nurturing," added Hill, who earned her undergraduate degree at Northwestern University.

"Programs like these are encouraging [for minority students] because they can see someone else doing some of the same things they want to do," she said.

SUPPORT PROGRAMS ALSO are important in breaking down barriers and myths about minorities and medicine, said Dr. Jones. One myth is that "minorities believe they can't get into medical school unless their grade point average is above a 3.3," he said. A second myth is that "minority students can't perform on standardized exams."

Jose Crespo, a second-year medical student at the Southern Illinois University School of Medicine, thinks another myth is that minorities are not interested in medical careers, a claim he said is ridiculous. "There is no difference between majority and minority students," said Crespo. "We all have the same ambition, but [the schools] prepare us differently."

In truth, Dr. Jones explained, preparation and reality building are all that it takes to succeed. "We need a lot less rhetoric and a lot more action," he added.

The basic nature of many of the medical school programs encourages one-on-one communication and close contact between prospective students, medical students and faculty, factors particularly important for minorities.

(Continued on page 14)



Ken Simpson

Minority students

(Continued from page 13)

"Majority students are able to see people like themselves all the time, and it is important for minority students to see that there are people like them also," said Lauren Bonner, a second-year medical student at SIU.

"Without this program, I would have been without orientation and guidance," said Baldemar Ugarte, a second-year medical student at UIC. "The contact I had with faculty and medical students made me realize that there were opportunities in the medical field." UIC's early outreach program helped Ugarte "polish up on math and chemistry skills" prior to medical school.

Unlike other Illinois medical schools, SIU offers a postbaccalaureate, nondegree program for those individuals who need additional training to prepare for medical degrees. The Medical/Dental Education Preparatory Program enables minority students to strengthen their science backgrounds, improve their study skills, prepare for the Medical College Admission Test and interact with medical students and faculty, said program director Harold Bardo, PhD.

The program proves that it is never too late to begin a career in medicine for those students with the desire to take advantage of resources, said Bonner, a former participant.

But students and experts agree that reaching future medical students at the earliest possible age is ideal. For that reason, Bonner and Crespo are developing a mentor program at SIU connecting medical students with students from local grammar schools.

"Fifth-graders have more potential to change their behaviors and beliefs," said Bonner. "We can help them establish a positive attitude and help motivate them and [help them] believe in themselves."

Crespo added, "We need to show these students that [medical school] is not as difficult as it seems." ■

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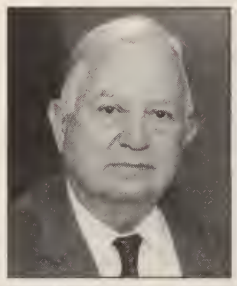
Drs. Johnson and Mitchell honored for community service

[MARTINSVILLE] As representatives of farming communities, farm bureaus work to ensure access and affordability of quality health care for all rural areas. The 75th annual meeting of the Clark County Farm Bureau honored two men who have dedicated themselves to achieving this goal.



Dr. Johnson

"Here are two local doctors of retirement age who never quit working for the community," said Paul Stephen, president of the Clark County Farm Bureau, speaking of Eugene P. Johnson, MD, and George T. Mitchell, MD. "They work for the people and have an interest in people at heart, and we felt their work needed to be honored."



Dr. Mitchell

Dr. Johnson, of Casey, has been associated with a medical practice established by his father and brother since 1946. Dr. Johnson has served as secretary-treasurer, trustee and president of ISMS, and co-chairs the ISMS Health Care Access Committee with Dr. Mitchell. He is also a member of the ISMIE Board of Governors. In addition to his role as a member of the Board of Trustees of the Illinois Academy of Family Physicians, Dr. Johnson is a medical consultant to the Illinois Department of Public Aid.

After he returned from the military in 1946, Dr. Mitchell, of Marshall, established a medical practice in his father's former office. Dr. Mitchell has served as vice president of ISMS and is a founding member of IMPAC. He has also served as a member of both the local board of education and the board of trustees of Lake Land Community College, and is currently president of the Clark County Medical Society. ■

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Busy dermatologist in southwest suburbs needs BC/BE dermatologist for partnership. Send resume to Box 2194 % *Illinois Medicine*, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Two busy Ob/Gyn practitioners in west suburban Chicago area need gynecologist for partnership. Send resume to Box 2227, % *Illinois Medicine*, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

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Physicians needed in all specialties. Full-time and part-time positions available as well as group or solo practice opportunities in Chicago/Illinois and multistate areas. Contact: Debbie Aber, Physician Services, 1146 Parker Lane, Buffalo Grove, IL 60089; (708) 541-9332, fax (708) 541-9336.

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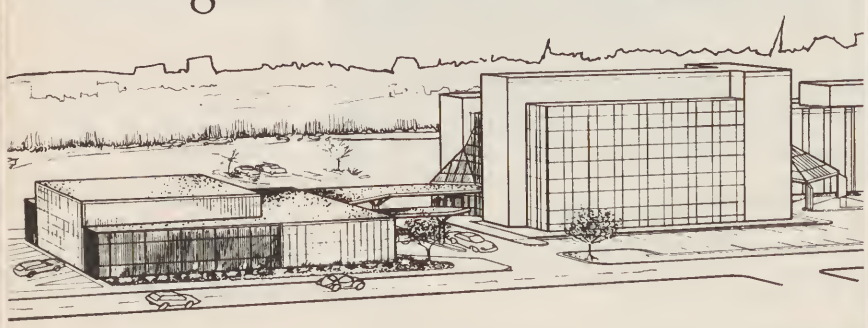
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Second Annual Clinical Neurology and Behavioral Sciences Symposium: Focus on Stroke, May 21-23, Landmark Inn Resort and Conference Center, Egg Harbor, WI. Contact: Marshfield Clinic, Office of Medical Education, 1000 N. Oak Ave., Marshfield, WI 54449; (800) 782-8581, ext. 5207.

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Allied health bills

(Continued from page 1)

For these reasons, Illinois physicians carefully watch all legislative attempts by nonphysician members of the health care team to garner an expanded role under licensure that might enable them to practice without physician direction.

After several unsuccessful tries last year to create a licensure category for lay midwives, these practitioners are renewing their efforts this legislative session. A bill sponsored by Rep. Mary Flowers (D-Chicago) is being considered by the House Registration and Regulation Committee. As written, H.B. 929 calls for establishment of educational and clinical experience requirements for the licensing of midwives. Although ISMS supports the practice of certified nurse-midwives who work under a physician's supervision, the Society is opposed to licensing lay midwives.

Care provided by ancillary health professionals should not be provided 'without the direction of a physician.'

A Senate bill of considerable concern is S.B. 333, introduced by Sen. Frank Watson (R-Carlyle) and supported by the optometrists. The bill amends the state's Optometric Practice Act by expanding the definition of optometry practice. Among the controversial aspects of the bill are provisions allowing optometrists to use therapeutic drugs.

A group of bills introduced by Rep. E.J. "Zeke" Giorgi (D-Rockford) are aimed at allowing nonphysicians – such as chiropractors and podiatrists – to gain hospital medical staff privileges and perform school physical examinations. H.B. 219 amends the Hospital Licensing Act to enable hospitals to grant staff privileges to any doctor licensed under the Medical, Dental and Podiatric Practice Acts. H.B. 220 would require HMOs to employ "sufficient" numbers of medical and dental providers, including chiropractors, to meet the needs of plan participants. Similarly, Rep. Frank Giglio (D-Calumet City) introduced a bill amending the state's HMO Act to require that chiropractors be made available to plan enrollees who request referrals for chiropractic services.

On the school exam front, Giorgi introduced H.B. 223, which would allow chiropractors to perform required school health examinations. Currently, the Illinois School Code specifies such examinations be performed by physicians licensed to practice medicine in all its branches, a designation limited to MDs and DOs. Giorgi's H.B. 221 calls for school boards to be banned from paying membership dues to interscholastic athletic associations unless those groups allow "free choice of all classes" of physicians – including chiropractors – to certify a student's physical fitness to participate in sports activities.

A House bill calling for the creation of utilization review requirements for chiropractic treatment remained in the Insurance Committee. The failed legislation was sponsored by Rep. Bob DeJaegher (D-East Moline).

Several other bills being considered by the House Registration and Regulation Committee may be used as vehicles for expanded practice for podiatrists, physical therapists, professional counselors and physician assistants.

Not currently licensed in Illinois, acupuncturists are now seeking licensure under state law to practice their profession. The legislative measure, H.B. 1957, is sponsored by Rep. Daniel Burke (D-Chicago). ISMS policy opposes independent licensure of acupuncturists. The Society believes acupuncture is a surgical procedure that should be performed only by a physician licensed to practice medicine in all its branches.

The deadline for nonappropriation bills to advance from committee for full floor consideration is March 26. *Illinois Medicine* will follow these and other legislative measures of interest to physicians during the spring legislative session. ■

Appropriations

(Continued from page 1)

number is so high."

Of the $269 million in supplemental general revenue funds Edgar is requesting, $180 million is slated for medical-related payments, Feldhausen said. The largest chunk of funding – $120 million – would be used to advance the cash flow of the state's Medicaid assessment program.

Because the last quarterly assessment payment for health facilities is due June 30, the money could not be turned around fast enough and used to reimburse institutional providers before the end of the current fiscal year, she explained. "It would be impossible to spend the money before the end of the fiscal year. It's a timing issue. We'd just be fronting the money."

Physicians, too, would benefit from the governor's supplemental request on behalf of the Department of Central Management Services. Edgar earmarked $15.9 million to help cover the "unfunded liability" for fiscal 1993 in the state employees' group insurance plan, Feldhausen said. The money will be used to pay overdue medical bills. "We'll still have to roll over some of our bills to next year, but this [supplemental funding] will help us pay more of our bills this spring."

The additional funding also will lower the amount of unpaid bills the state will face for the employee insurance fund next year.

The Department of Alcoholism and Substance Abuse would receive $10.5 million if the General Assembly approves Edgar's supplemental funding list. Of that total, $2 million would pay outstanding treatment bills from fiscal 1992 and $8.5 million would be applied to fiscal 1993 bills, Feldhausen said.

After losing a court case this year, the state's Department of Rehabilitation Services has a shortfall of $16.6 million, the budget office said. The state had tried to limit the number of new home-care clients it accepted and budgeted for only the lower number of clients. But the "court said we could not cap the home services program," Feldhausen said.

Supplemental appropriations

(figures in millions)

DASA	$ 10.5
CMS (state employee health plan)	$ 15.9
Public aid (Medicaid assessments)	$120.0
Rehabilitation services	$ 16.6
Court of claims (Medicaid interest payments)	$ 17.0

"The department is still accepting new clients," which is creating the shortfall.

To cover interest owed on medical bills, an additional $17 million in supplemental funding would be funneled to medical providers through the state's Court of Claims. The interest payments would be made only on those overdue claims submitted prior to changes enacted in the Prompt Payment Act during fiscal 1992, Feldhausen said. ■

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Health committee

(Continued from page 1)

members have not enjoyed for more than a decade.

"We are now conservative to moderate on social policy and definitely conservative on fiscal issues," said Committee Chairman Judy Baar Topinka (R-Berwyn), noting that the new Republican majority could end the committee's previous trend of passing "too many bills that add to the cost and burden of health care."

"I'm thrilled about the makeup of the committee," said Vice Chairman Dan Cronin (R-Elmhurst), adding that in his previous position as a freshman minority House member he had little influence. "There is a camaraderie among Senate Republicans that is very pleasant. There is a feeling of responsibility. We have an agenda and a philosophy. I'm optimistic about working together with the governor leading the way."

But even with a Republican majority, committee leaders still expect a wide range of opinions on some of the upcoming bills. But the emphasis will be on cost containment, Topinka said. "We will look at bills in terms of cost and pay particular attention to expanding programs already in place, to fine tune them for the most productivity."

According to Cronin, the biggest issue in the picture for the Public Health and Welfare Committee is the Medicaid budget. With "exploding Medicaid costs, it's the most onerous, burdensome item" on the agenda, he said. Discussions are ongoing between the governor's office, the Illinois Hospital Association, legislators and nursing homes to decide whether to renew the state's hospital assessment plan or find an alternate funding source.

Despite some vocal legislative opposition to assessments, support for the program's continuation does exist. A health care reform task force appointed by the governor studied the issue and concluded that the assessment plan should continue on a temporary basis because of the lack of viable alternatives. Acknowledging it is not the best option, the task force said failing to extend the program would create a $1.5 billion hole in the state budget, leading to severe reimbursement rate cuts for health care facilities treating the poor. Gov. Jim Edgar and Department of Public Health Director Phil Bradley have also said publicly that they support continuing an assessment plan of some kind, although they are open to changes in the program's structure.

> *There is a camaraderie among Senate Republicans that is very pleasant. There is a feeling of responsibility. We have an agenda and a philosophy. I'm optimistic about working together with the governor leading the way.*
>
> **SEN. DAN CRONIN**

In fact, Edgar's proposed fiscal '94 budget specified that an assessment program would be in place by the end of the legislative session without detailing the form of that program. The governor said he expects the plan to take shape once the federal government announces promised relaxations in rules governing matching fund programs. With or without the federal action, he said some legislative action will be necessary by fiscal year end, when the current assessment program expires.

"We're hoping for latitude on federal waivers for Medicaid," Topinka said, voicing her contempt for the "granny tax," the state matching fund program assessing hospitals and nursing homes. Physicians are not assessed under the program.

She predicted that the assessments will be obliterated by legislators because they are "bad public policy" that if extended will only perpetuate current problems with the system. The committee is now hearing testimony on the value of reinstating a food and drug sales tax that was in effect until 1984 to fund Medicaid. Topinka revived the food sales tax concept late last year. "A cut in rates to nursing homes and hospitals is a nonsolution," Topinka said.

"THE STATE IS IN A PECULIAR position right now," Cronin said, alluding to the Clinton administration's possible sweeping plans for health care reform. "It scares me to think about what may come out of Washington."

Illinois can either wait and see the outcome of the Clinton plan or push forward with its own plan, Cronin said. He supports the latter, and foresees a multifaceted program encouraging risk pools and including health care savings accounts and tort reform.

Topinka said she supports a federal immunization program, explaining that expanded health care options for women and children, including prenatal workups, will help "healthy babies grow into healthy adults, creating a healthier society."

To help cut health care costs and create more competition, Topinka is sponsoring a bill amending the Alternative Health Care Delivery Act. The bill proposes birthing centers and postsurgical recovery care centers as authorized health care delivery models. ISMS House of Delegates policy supports pilot postsurgical centers, but not freestanding birthing centers, since they do not conform with American College of Obstetricians and Gynecologists guidelines.

"Roll calls will not be the same this year for every bill," Topinka said, noting that she doesn't know where all her colleagues sit on such issues as abortion and expanding the roles of allied health care workers.

Committee Minority Spokesperson Margaret Smith (D-Chicago) is placing universal health care at the top of her agenda. "If I had my way, it would pass right away," she said. "There has got to be something put in the hopper when there are so many people without health care services." Smith is hoping for reform at the federal level, but added, "We can't go to sleep at the state level."

Other legislation Smith hopes to see pass this year include several AIDS confidentiality and testing bills, a childhood immunization bill and expanded health care for minorities and non-English-speaking Illinoisans. Some of the Democratic priorities, such as a state-run, single-payer health system, are contrary to the objectives of organized medicine, according to legislative observers.

Although concerned about the Republican majority in her committee, Smith said, "We'll do the best we can. Health is my No. 1 priority. We need to keep people healthy." ■

Council

(Continued from page 1)

in Illinois and its contiguous states. In the council's 1992 report to the Board of Trustees, it concluded that overall Illinois did well, filling 82.3 percent of all positions, compared with the national average of 79.7 percent. The council also made these observations:

- Although the number of family practice positions filled in Illinois was less than the national average for this specialty, Illinois continued to increase the percentage of positions filled in family practice. In 1991, Illinois filled only 55.5 percent of its family practice positions, but in 1992, 60.1 percent of positions were filled. The national average was 67.5 percent.
- Illinois' fill rate was greater than that of Indiana, Kentucky, Michigan and Missouri. Of Illinois' contiguous states, only Iowa and Wisconsin had higher fill rates, 83.7 percent and 84 percent respectively. However, Iowa and Wisconsin had significantly fewer positions than Illinois did.

Other findings were that for some specialties – for instance, anesthesiology, pediatrics and internal medicine – Illinois filled a higher number of positions than the national average.

In its report, the council said it was encouraged by the gradual progress in filling family practice positions, but noted that the picture may be skewed if Chicago programs were compared with those downstate.

David C. Garretson, MD, a member of the council and a family physician in Belleville, said of the statewide situation for family physicians, "Chicago programs do relatively well, but outside of Chicago, things don't always look as well. Hopefully, we have hit the bottom. I just received the figures today, and overall, it looks like Illinois did well. It appears as if family physician positions have gone up statewide."

"Our primary concern is what Illinois schools do," said Robert M. Vanecko, MD, a thoracic surgeon in Chicago, and an ISMS trustee and board consultant to the council. "Illinois schools are a large exporter of physicians." ■

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Budget benefits

(Continued from page 4)

$712.8 million, including nearly $136 million from employee-paid premiums, said Lynn Calame, Bureau of Benefits manager. The plan is administered through the state's Department of Central Management Services.

"The general revenue fund increase will fully fund the estimated liability for next year, but we'll still have to deal with a shortfall," Calame said. "If we get the governor's budget as proposed, we'll have a shortfall of about $64 million." Despite this shortfall, the payment cycle is expected to come down substantially during fiscal '94.

Physician and other medical provider bills included in the '93 shortfall will be paid at the beginning of the 1994 fiscal year, which begins July 1. Even with increased funding, the plan is dependent on cash flow in the comptroller's office to pay medical bills. The current payment cycle for physicians and other non-PPO providers is 80 to 82 days, Calame said, adding that employees who pay their own medical bills out-of-pocket are reimbursed in 37 to 38 days.

"We're really pleased with the budget as it was introduced. We'll work hard to see it gets passed as is."

Watch future issues of *Illinois Medicine* for in-depth coverage about the impact of the governor's budget proposal on other state agencies providing health care services. ■

OBITUARIES

* indicates ISMS member
** indicates member of ISMS Fifty Year Club

***Anagnost**
Maria Anagnost, MD, a surgeon from Chicago, died Dec. 2, 1992, at the age of 49. Dr. Anagnost was a 1973 graduate of the University of Illinois College of Medicine, Chicago.

***Arida**
Gamil T. Arida, MD, a urological surgeon from Flat Rock, N.C. (formerly of Joliet), died Oct. 26, 1992, at the age of 68. Dr. Arida was a 1948 graduate of the Faculty of Medicine, Alexandria University, Alexandria, Egypt.

****Brandman**
Harry Brandman, MD, a psychiatrist from Galesburg, died Nov. 18, 1992, at the age of 88. Dr. Brandman was a 1930 graduate of Rush Medical College, Chicago.

****Buyer**
Morris Buyer, MD, a general practitioner from Des Plaines, died Dec. 17, 1992, at the age of 81. Dr. Buyer was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

***Conklin**
Robert A. Conklin, MD, a thoracic surgeon from Bloomington, died Nov. 29, 1992, at the age of 68. Dr. Conklin was a 1954 graduate of the University of Illinois College of Medicine, Chicago.

****Cordray**
David P. Cordray, MD, an ophthalmologist from Lake Forest, died Dec. 1, 1992, at the age of 87. Dr. Cordray was a 1936 graduate of the University of Pennsylvania School of Medicine, Philadelphia.

***Dolan**
Richard H. Dolan, MD, a family physician from Libertyville, died Nov. 5, 1992, at the age of 60. Dr. Dolan was a 1957 graduate of the University of Illinois College of Medicine, Chicago.

***Freedom**
John Freedom, MD, an obstetrician/gynecologist from Palos Park, died Dec. 6, 1992, at the age of 60. Dr. Freedom was a 1950 graduate of The Medical School University of Birmingham, Birmingham, England.

****Geller**
Joseph Geller, MD, a family physician from River Forest, died Oct. 27, 1992, at the age of 77. Dr. Geller was a 1942 graduate of Chicago Medical School.

****Hunt**
Jordan A. Hunt, MD, a general practitioner from Riverside, died Dec. 1, 1992, at the age of 84. Dr. Hunt was a 1937 graduate of McGill University Faculty of Medicine, Montreal, Quebec, Canada.

****Keeley**
John L. Keeley, MD, a surgeon from North Riverside, died Nov. 25, 1992, at the age of 88. Dr. Keeley was a 1930 graduate of Loyola University Stritch School of Medicine, Maywood.

****Levy**
Robert C. Levy, MD, an internist from Chicago, died Dec. 23, 1992, at the age of 86. Dr. Levy was a 1929 graduate of Rush Medical College, Chicago.

****Serby**
Abraham M. Serby, MD, an internist from Chicago, died Dec. 2, 1992, at the age of 94. Dr. Serby was a 1922 graduate of the State University of New York Health Science Center at Syracuse, College of Medicine, Syracuse, NY.

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ENTIFY AND HELP IMPAIRED PHYSICIANS (PAGE 9)

House considers smoking bills

PAGE 4

Illinois Medicine

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Detecting the signs of depression and anxiety

PAGE 12



Ron Ackerman

Arvind K. Goyal, MD (left), and Rep. Tom Ryder present testimony supporting H.B. 1432, Ryder's bill that proposes a $250,000 cap on malpractice and other tort awards. The bill failed to pass out of committee March 24.

Caps legislation advances in Senate, dies in House

TORT REFORM: Despite the movement of caps legislation out of Senate committee, physicians still face an uphill battle. By Anna Brown

[SPRINGFIELD] Members of the Illinois Senate Judiciary Committee voted 6-5 March 25 to advance a bill that would cap noneconomic tort awards, including medical malpractice damages, at $250,000. However, identical legislation failed to emerge from the House Judiciary Committee March 24.

The advancement of S.B. 344, sponsored by Sen. Thomas J. McCracken Jr. (R-Downers Grove), might seem to be a turning point in tort reform for Illinois physicians battered by the current malpractice climate. But given the close vote in the Senate committee and the death of H.B. 1432, sponsored by Rep. Tom Ryder (R-Jerseyville), chances are slim that the bill will move through both houses and reach the governor's desk.

Nevertheless, ISMS President Arvind K. Goyal, MD, cited the advancement of the Senate bill as significant.

"We are extremely pleased with the outcome of the Senate committee hearing," Dr. Goyal said. "A cap on noneconomic losses would prevent huge lottery-type awards paid to a few at the expense of everybody else."

BUT DR. GOYAL INSISTED that bringing the bill out of committee is only a first step toward enacting a caps law. "There is still a lot of work to be done to promote this legislation to law-

(Continued on page 21)

INSIDE

ISMS prepares for 1993 Annual Meeting
PAGE 15

ANNUAL MEETING 1993

Town hall meetings target health care
PAGE 3

Illinois law and financial planning
PAGE 16

DEPARTMENTS

News Briefs....2, 3
Commentary...6, 7
ISMIE Update 9
Obituaries 18
Classifieds 19

It's back!

Universal health bill advances in House

H.B. 1459: A partisan roll call moves Rep. Bill Edley's Vermont-style state-controlled health reform bill out of committee. By Anna Brown

[SPRINGFIELD] After failing in committee on its first attempt, H.B. 1459 advanced out of the House Health Care and Human Services Committee March 31 by a 16-8 vote, bringing new life to the prospect of a government-run, single-payer health care system in Illinois. H.B. 1459, sponsored by Rep. Bill Edley (D-Macomb), would require Illinois to study and implement a state-directed and state-regulated health care system modeled after the Canadian system and Vermont's health care plan. The plan would have to be implemented by Jan. 1, 1996.

The bill's advancement marks Illinois physicians' return to battle over an issue that had been successfully wiped out last year.

H.B. 1459 specifically calls for the creation of a bipartisan health care reform commission that must focus its recommendations on two particular plans of health care reform: a single-payer, tax-funded system based on the Canadian model and a heavily regulated, multi-payer system. ISMS President Arvind K. Goyal, MD, explained that there would be no substantial difference between the two, as

(Continued on page 22)



Wm. Daniels/The Photo Partners

MEDICAL STUDENTS AT the University of Illinois College of Medicine in Chicago, like medical students all over the country, received their residency assignments on Match Day, March 17. From left, George Brennan, Allison Van Egeren, Darin Dougherty and Tom Brander celebrate receiving their first choices. See story, page 17.

ISMS BEHIND THE SCENES

A CALL TO ARMS: GET INVOLVED

Read this issue of *Illinois Medicine* closely and you'll see why it's crucial for physicians to become prominent players in the political process. Too much is at stake in Springfield this legislative session for physicians to remain on the sidelines.

Supporters of so-called universal health care plans are again pushing their unwise proposals for health care reform – and through political maneuvers are enjoying some minor successes moving their legislation out of committee. And although the ISMS-supported noneconomic damage award bill advanced to the Senate floor, a companion bill in the House was soundly defeated.

"We must know how the legislators voted on these bills – and others with direct effects on patient care," said ISMS President Arvind K. Goyal, MD. "Don't let them hide behind the final committee votes. Each one cast a vote. If they are making decisions that adversely impact the availability and cost of health care, we must let them know about it. Call them. Write them. Make them take

(Continued on page 22)

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ISMS PRESIDENT-ELECT Arthur R. Traugott, MD, and ISMS Second Vice President Richard A. Schmidt, MD, led a group of physicians to Washington, D.C., March 23-25 to learn more about the president's plan for health care reform. AMA Trustee P. John Seward, MD (at right), of Rockford, introduced U.S. Rep. Newt Gingrich (R-Ga.), who spoke to physicians and challenged the sincerity of the Clinton administration's pledge to enact tort reform.

Kids tell Joe Camel to kick the habit

[CHICAGO] A contest sponsored by the AMA and the U.S. Surgeon General will urge kids to tell "Old Joe Camel" to say no to cigarettes.

Surgeon General Antonia Novello, MD, and the AMA launched the "Say No, Old Joe" contest March 10. They encouraged children in kindergarten through eighth grade to write a letter, poem or essay or draw a poster telling the cartoon cigarette spokesperson why he shouldn't smoke.

A study published in the December 1991 *Journal of the American Medical Association* reported that children recognized the "Old Joe Camel" character as readily as the Mickey Mouse logo from the Disney cable television channel.

Contest winners in each of three age groups will receive a $200 U.S. savings bond and a trip to Washington to meet Dr. Novello. Each winner's school will receive a $5,000 grant for educational materials or recreational equipment.

To receive contest information, contact Lisa Levin at the AMA at (312) 464-2410. ■

ISMS testifies at domestic violence summit

[CHICAGO] Calling on physicians and the public to work together to help victims of abuse, ISMS President Arvind K. Goyal, MD, testified in Chicago at a March 18 emergency summit on family violence, convened by Illinois Attorney General Roland Burris.

"The emotional, physical and sexual abuse of young children, spouses and elderly people is a public health epidemic costing our country's health care system billions of dollars in treatment for its thousands of victims," said Dr. Goyal.

He outlined organized medicine's role in combating the "runaway epidemic" of domestic violence to a panel of state's attorneys from Cook, DuPage and Lake counties; and representatives from the legal community, the Illinois Women's Bar Association and the Illinois Coalition Against Family Violence. Other speakers included victims of domestic violence and representatives from battered women's shelters.

Last year in Illinois, more than 130,000 children and between 200,000 and 300,000 women were beaten, abused or killed in their own homes, Dr. Goyal said. Statistics show that 35 percent of women seeking medical care in emergency rooms are victims of domestic violence, he noted.

"Physicians, who see many of these victims in various health care settings, are in a unique position to offer assistance," Dr. Goyal said. "Because the physician-patient relationship relies on trust and honesty, a physician is one of the few people with whom victims can speak honestly."

The medical profession has demonstrated an ongoing commitment to end the violence and advocate for increased services for victims and abusers, said Dr. Goyal. Programs such as the AMA's Campaign Against Family Violence help physicians recognize abuse, encourage victims to seek help and urge others to get involved, he added. ■

IDPA starts downstate HMHK recruiting

[SPRINGFIELD] If you are a suburban or downstate primary care physician, you should have recently received a letter inviting you to participate in public aid's new Healthy Moms/Healthy Kids program. All primary care physicians who have hospital admitting privileges and who are currently enrolled as Medicaid providers are eligible to participate. Suburban-area physicians currently caring for Medicaid clients who live in Chicago and who have signed a Chicago HMHK agreement will automatically be enrolled in the suburban and downstate program. The program was slated to begin April 1.

Unlike the Chicago program, the suburban and downstate HMHK initiative is not a managed care program. Under the HMHK program, physicians are responsible for managing and coordinating patients' care, but other health care providers are not required to get approval from the primary care physician before administering care. In the Chicago HMHK plan, a patient's primary care physician must approve all care before reimbursement will be approved by Medicaid. Left unclear in the suburban and downstate program is the physicians' responsibility if their patients seek and receive care from another source without notifying them.

ISMS is concerned about this unanswered question and has expressed concerns over several other areas of the program that have yet to be addressed. These include certain administrative and accessibility aspects, and the fact that the quality assurance process is not yet specified. Before signing the contract to participate, ISMS advisers recommend that physicians read the HMHK Physician Handbook and enrollment form carefully so that they understand their responsibilities under the new program. Any primary care physicians who did not receive a letter and are interested in participating in the program should contact IDPA. ■

Study finds racial disparities in health care exec careers

[CHICAGO] According to a study released by the American College of Health Care Executives and the National Association of Health Services Executives, a disparity exists between the career attainments of African-American and Caucasian health care executives.

The study found that even though the two groups had few demographic differences – such as age and educational background – fewer African-Americans hold CEO positions or positions reporting to the CEO, and fewer African-Americans are in general management. They also found a substantial difference in salaries between the two groups, with African-American executives earning a median income of $53,000 in 1990, compared with $67,000 for Caucasian executives.

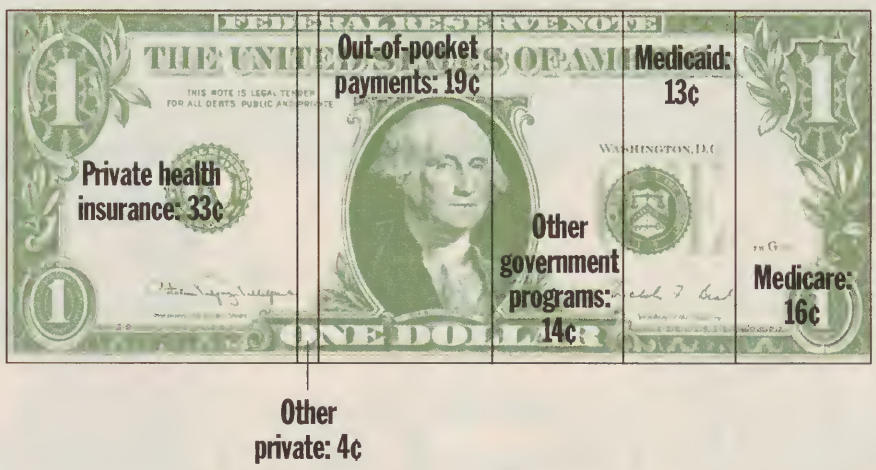
"While this study suggests that blacks have, regretfully, not yet achieved the same positions and salaries in health care management as their white counterparts, we are confident that by understanding the basis for these discrepancies, our profession will be better equipped to help correct the situation," said Thomas C. Dolan, president and CEO of ACHE.

Based on the findings of the study, ACHE and NAHSE have recommended ways that health care organizations and professional associations can address some of the existing disparities. They include recruiting and promoting African-American managers, involving African-American managers in recruitment, and developing policies to encourage affirmative action and equal employment opportunities. They also recommend that a comparable study be conducted in three to five years to measure progress. ■

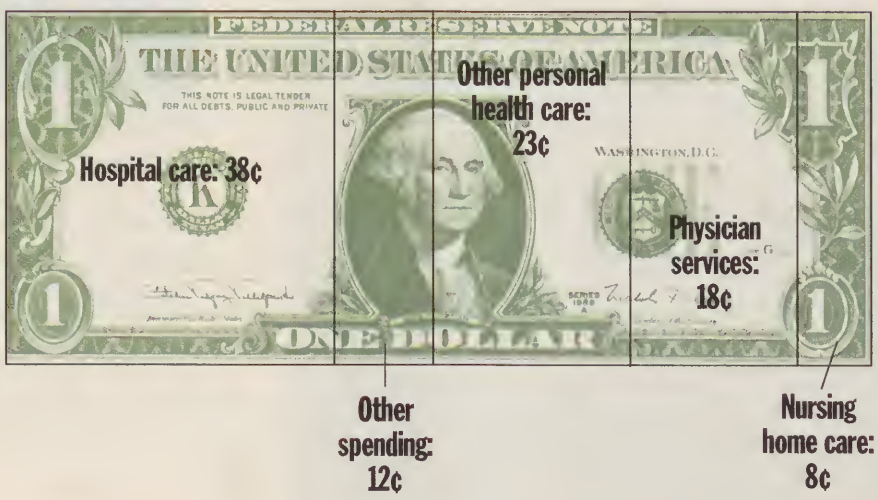
PHYSICIAN FACTS

The nation's health dollar in 1991

Where it came from ...



... and where it went



Source: U.S. Health Care Financing Administration

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Town hall meetings target health care

REFORM: An Illinois congressman calls downstate communities to action in the search for a cure to the health care crisis. By Gina Kimmey



Christiann Baxter

Dr. Hays represented organized medicine on a panel at one of Rep. Glenn Poshard's town hall meetings on health care reform held last month in several downstate communities.

[HERRIN] How can we reform health care? The question has been asked many times, many ways, by many people. Recently, 19th District U.S. Rep. Glenn Poshard (D-Marion), a member of the House of Representatives' Rural Health Care Coalition, looked for answers to that question at town hall meetings conducted in several downstate communities. William Hays, MD, a family physician from Herrin, represented organized medicine on the panel at a March 22 meeting at Herrin Hospital.

Participants with varied viewpoints testified on behalf of such groups as organized labor, senior citizens and consumer rights advocates. The discussion centered on rising health care costs and the pros and cons of a universal system, such as the one in Canada. Poshard is on record as supporting a single-payer, Canadian-style health care system.

"We just don't have enough primary care doctors for the Canadian system to work here," said Dr. Hays. "Today, a primary care doctor may see 20 or 30 patients a day. With a Canadian-type system, that number could rise to as many as 40, 50 or even 60 patients. The manpower just isn't available."

Dr. Hays said reform should focus not on costs, but on the factors driving those costs. "Health care is said to be 13 to 14 percent of the GNP, but if you take out the cost of malpractice insurance, defensive medicine and claims, that percent could go down to 8 or 9," he added.

THE IMMENSE ADMINISTRATIVE constraints placed on physicians require them to hire office staffs, spend hours on the phone with insurance companies and tackle voluminous paperwork every day, he said. "We [doctors] have been regulated and mandated until we are almost ineffective. We spend so much time on social work, paperwork and administration that we have almost no time left for the treatment of disease." Dr. Hays told participants that these issues must be addressed for health care reform to work.

In Decatur, Ronald L. Ruecker, MD, an internist and an ISMS Seventh District Trustee, testified at Poshard's town hall meeting at Decatur Memorial Hospital. Dr. Ruecker told the panel that Illinois physicians are committed to working with the government and other members of the health care community to find an affordable, workable solution to the problem. He agreed with Dr. Hays that the hassle factor has contributed to the increasing burden on physicians, which results in higher costs.

When the discussion turned to rationing, Dr. Ruecker was asked who should be making those decisions.

"Not doctors," he answered. "Doctors are not trained to withhold care; they are trained to provide care." He said the burden of rationing should be decided by the whole society, not doctors alone. ■

NIH director asked to resign post

[WASHINGTON] Although she lobbied to keep her job under the Clinton administration, National Institutes of Health Director Bernadine P. Healy, MD, will resign effective June 30 at the request of the president.

The tenure of Dr. Healy, a cardiologist and the first woman NIH director, was marked by her initiative to conduct research in women's health concerns.

Meanwhile, President Clinton will retain Food and Drug Administration Commissioner David Kessler, MD. FDA chief since 1990, Dr. Kessler has helped hasten drug approval processes, cracked down on pharmaceutical advertising practices and won new food labeling requirements. ■

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REPORT FOR *Illinois Physicians*

MEDICARE

New Medicare Medical Director -- John F. Nutting, Senior Vice President, Government Contracts Division of Blue Cross and Blue Shield of Illinois, recently announced the appointment of Douglas E. Busby, M.D., as the new Medical Director of Medicare of Illinois. Dr. Busby succeeds Charles C. Henderson, who remains as part-time consultant.

Dr. Busby received his M.D. (cum laude) from the University of Western Ontario in 1960, and had subsequent training in general surgery, cardiovascular biophysics (M.Sc.), and preventive, aerospace, and occupational medicine. He is a diplomate of the American Board of Preventive Medicine in aerospace medicine, and is qualified by this Board in occupational medicine. He is a Fellow of the American College of Preventive Medicine, is a member of several professional organizations including the Illinois State Medical Society, and has authored 26 scientific publications including a section in the Encyclopedia Britannica.

Dr. Busby will continue Dr. Henderson's tradition, in always being available to the provider community. Dr. Busby can be reached at (312) 938-7931.

Clinical Practice Guideline - Cataracts -- We applaud the development of the new clinical practice guideline, "Cataract in Adults: Management of Functional Impairment", by the Agency for Health Care Policy and Research (AHCPR), Public Health Service, U.S. Department of Health and Human Services. The guideline, with an accompanying quick reference guide for clinicians and a guide for patients, will enable those with cataracts to make better informed decisions on need for cataract surgery.

This guideline, the fourth from AHCPR, was developed by a private-sector, multi-disciplinary panel chaired by Dennis O'Day, Chair of the Department of Ophthalmology at Vanderbilt University's School of Medicine. The panel reviewed nearly 8,000 published studies on cataract care, as well as information provided by consultants, specialty societies and others. The draft guideline was widely circulated to cataract experts for review and comment before being finalized.

The guideline does not recommend cataract surgery solely to improve vision if the patient does not desire this surgery, glasses or visual aids provide satisfactory functional vision, the patient's lifestyle is not compromised, or the patient is medically unfit. Cataract surgery is absolutely necessary only in the presence of diseases such as glaucoma and diabetic retinopathy.

About 1.35 million cataract surgeries were performed in 1991, at a cost of $3.4 billion to Medicare alone. Cataract surgery is the most common surgical procedure performed on persons over age 65 in the United States (and in Illinois). Although AHCPR has emphasized that the guideline does not, in any way, restrict access of patients to needed cataract surgery, but states that if functional impairment caused by a cataract can not be improved to the patient's satisfaction by simple methods, surgery is appropriate and reasonable.

Copies of the guideline and its accompanying guides are available free from the AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD, 20907, or by calling (800) 358-9295.

(Issue: 04/09/93 - MedB)

House considers stricter smoking limits

SMOKING BILLS: State legislators debate regulating the sale and use of tobacco. By Anna Brown

[SPRINGFIELD] During committee hearings March 22-31, state legislators addressed new bills regulating the sale and use of tobacco. Rep. John Dunn (D-Decatur) introduced all of the following measures, which ISMS supports to promote healthier, smoke-free environments in Illinois.

The introduction of H.B. 1576 was prompted by new federal law requiring states to enact legislation prohibiting the sale of tobacco products to minors or lose federal block grant funds. The bill, the only successful smoking-related measure, passed in committee on a 9-1 vote. H.B. 1576, which would create the Prevention of Access of Children to Tobacco Products Act, would prohibit the sale of tobacco products to children under age 18. All retail tobacco dealers would be required to purchase permits for each place in which tobacco is sold. The new Act would define tobacco-dealer qualifications and the parameters for issuing and renewing permits. The bill also calls for monitoring cigarette vending machines to prevent minors from purchasing tobacco products. ISMS supported this legislation.

ISMS STRONGLY SUPPORTED H.B. 1988, which would have defined open and enclosed stadiums as public places. This designation would have subjected stadiums to all smoking restrictions imposed under the Clean Indoor Air Act of 1990. The ISMS House of Delegates has vigorously opposed smoking at any public or private event in open or closed stadiums, and has sought the assistance of anti-smoking organizations and the AMA to help enact such legislation. The bill was not called in committee.

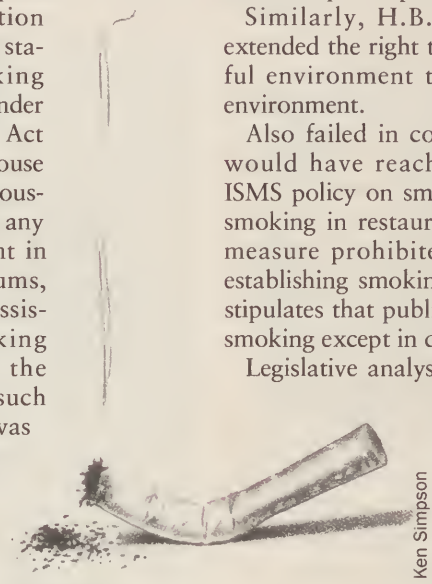
Three other smoking bills introduced would have benefited nonsmokers by creating smoke-free environments, as well as ensuring that local ordinances conform with the Clean Indoor Air Act. H.B. 1149, H.B. 1150 and H.B. 1152 would have amended the Act, but all three were overwhelmingly defeated in committee. H.B. 1149 would have allowed concurrent smoking regulation by any local government but prohibited any regulation inconsistent with the Act.

H.B. 1150 would have underscored all Illinois citizens' right to a "clean and healthful environment," as is guaranteed under the Act. The measure would have given priority to nonsmokers' health concerns, overriding the privilege to smoke in public places.

Similarly, H.B. 1152 would have extended the right to a clean and healthful environment to include the work environment.

Also failed in committee, H.B. 1481 would have reached beyond current ISMS policy on smoking by banning all smoking in restaurants. As written, the measure prohibited restaurants from establishing smoking areas. Current law stipulates that public buildings must ban smoking except in designated areas.

Legislative analysts attributed the failure of some of these bills to the strength of the tobacco lobby, including companies such as Phillip Morris. ■



Ken Simpson

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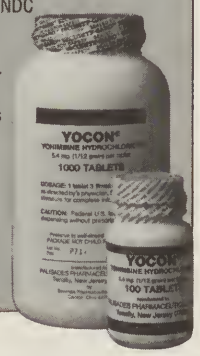
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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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Survey highlights IMPAC's voice

LAWMAKERS' OPINIONS: A survey polling state legislators covers topics ranging from health care to Gov. Edgar's influence. By Anna Brown

[CHICAGO] Seventy-eight percent of Illinois legislators responding to a survey rated the overall effectiveness of political action committees as very effective, effective or average. The 59-question survey was conducted by the St. Louis-based Fleishman-Hillard, Inc., a public relations consulting firm. About 60 percent of the General Assembly responded to the telephone and fax survey.

Illinois legislators called the ISMS Political Action Committee one of the three most influential PACs in the state. Other political action committees cited as being among the most influential include those of the Illinois Trial Lawyers Association and the Illinois Manufacturers Association.

> *At first blush, it seems gratifying and exciting to be among those receiving such recognition. But the trial lawyers are named as well, and this is not the time for us to rest on our laurels.*

"At first blush, it seems gratifying and exciting to be among those receiving such recognition," said IMPAC Chairman George T. Wilkins Jr., MD. "But the trial lawyers are named as well, and this is not the time for us to rest on our laurels. IMPAC must continue to push forward. We can do this only with the ongoing strong financial support of Illinois physicians."

When asked what they consider the most pressing issues facing the state, legislators listed the budget, education and health care. Lawmakers said health care costs and education funding were the second most pressing issues.

In the area of health care reform, 61 respondents favored private sector funding to provide universal health care access. The likelihood of passing a state-funded health care program in Illinois was rated very unlikely by 19.6 percent, unlikely by 32.7 percent, average by 35.5 percent, likely by 10.3 percent and very likely by .9 percent.

Respondents said legislation on unfunded mandates, the "granny tax" (the Medicaid matching fund program assessing nursing homes), and the death penalty were examples of legislation respondents felt should be repealed. Furthermore, legislators believe they are spending too much time addressing the "gambling issue, nitpicking and introducing too many bills."

Gov. Jim Edgar's influence has

(Continued on page 23)

Governor's new state board of health swings into action

ADVISORY PANEL: Appointed by Gov. Jim Edgar, board members set their sights on coordinating the efforts of IDPH and improving the health of Illinois. By Gina Kimmey

[SPRINGFIELD] To streamline the process of advising state officials on public health policy, the governor has appointed 14 members of the health care community to a new state board of health. The board was formed after legislation enacted in 1991 called for replacing the state health advisers with a permanent board of health. The board will oversee all the rule making of IDPH's other advisory boards and will inform the public about state public health programs.



Dr. McGee

"The state board provides IDPH with an independent source of expertise that we can rely on for policy information," said IDPH Director John R. Lumpkin, MD. The board consists of six physicians and eight representatives from the health care community, including nurses, dentists, and members of county health departments and local boards of health.

James L. McGee, MD, a Peoria Heights therapeutic radiologist and chairman of the ISMS Council on Medical Services, is the new board chairman. He sees one of the board's primary goals as building closer working relationships between the agencies of IDPH, ISMS, and the county medical societies and health departments. Dr. McGee said the board will work as a coordinating body to spread the word about IDPH's agencies and programs.

"Programs implemented at the state level will be more successful with the awareness and support of all state and county health agencies," said Dr. McGee. "By working together we will form an alliance for better health in Illinois." The board will also evaluate all committees and agencies run by the state health department and report back to Dr. Lumpkin and the governor.

The board's first meeting, held March 8, provided an overview of the board's functions. Members developed bylaws and established an agenda of topics to review, including immunizations, said Dr. McGee. The board also appointed a rules committee and will review public health legislative rules at the next meeting, scheduled for sometime in June.

Donald S. Ross, MD, a general surgeon from Springfield, is one of six physicians appointed to the board. "We will work to provide positive input into public health policy recommendations that the governor will hopefully implement," said Dr. Ross. He sees his role on the board as an opportunity to represent the viewpoint of the practicing physicians in Illinois.

Other physicians on the board include Karen L. Scott, MD, of Palatine, vice chairman of the new board and director of the Cook County Department of Public Health; Michael G. Murphy, MD, a Belleville neurosurgeon; Virendra S. Bisla, MD, a Flossmoor cardiologist; and Bernard J. Turnock, MD, of Chicago, associate dean of the UIC School of Public Health. ■

ISMS PRESIDENT ARVIND K. Goyal, MD, was a guest speaker at this year's Midwest Clinical Conference, held March 5-7 in Chicago. Dr. Goyal discussed health care reform and the need for physicians to work together to solve the nation's health care problems.



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EDITORIAL

The drama in Springfield

Illinois physicians need to know about the drama being played out in Springfield. You also need to thank some unsung heroes. Chief among them are Senate Judiciary Committee members who voted for a cap on noneconomic awards and moved S.B. 344 out of committee. They are Sens. Barkhausen, Cronin, Fitzgerald, McCracken, Petka and Topinka. Senators voting against the bill were Cullerton, Dunn, Hawkinson, Molaro and Stern.

ISMS President Arvind K. Goyal, MD, went to Springfield March 24 to testify in the House committee and on March 25 to testify in the Senate committee. He was peppered with tough questions by legislators opposing caps, and anti-cap testimony focused on the same old tired plaintiff attorney rhetoric. ISMS testimony centered on the fairness of capping noneconomic portions of awards while leaving intact full compensation for those truly injured through malpractice.

The Senate vote resulted from the hard work of ISMS and member physicians, who helped legislators understand the importance of tort and malpractice reform. The emergence of Republican Senate President James "Pate" Philip as a strong proponent of tort reform also played a major role.

The House of Representatives was a different story. Its Judiciary Committee, with many representatives who don't listen to medicine, defeated caps soundly. Nevertheless, our unsung hero in the House is Rep. Tom Ryder, who sponsored the bill. Representatives who voted "do not pass" were Blagojevich, Dart, Hoffman, Homer, Kaszak and Lang. Reps. Biggert, Cross, Rutherford and Stephens voted against the do-not-pass motion. Johnson voted present.

Illinois Public Action, in concert with plaintiff attorneys, is not hiding its strategy this legislative session. It's behind some harmful legislation introduced to try to keep the medical society too busy to fight the caps battle – like the attempt to raise your licensure fee to $500. Another IPA-supported initiative, H.B. 1459, would require the state to consider two options: a single-payer, state-run system or a government-regulated, multi-payer system. The bill got out of committee recently and must be stopped.

A victory for patients was the failure of a Senate bill that would have expanded optometrists' practice beyond their training. And a bill expanding psychologists' practice also failed to emerge from committee. But the idea of allowing allied health practitioners to work beyond their training is faring well in the House, as evidenced by the acupuncturists and nurse practitioners bills' advancing to the House floor.

Illinois physicians must continue to communicate with state lawmakers about the hazards of universal health care and the dangers to patients if allied health practitioners are allowed to practice outside the scope of their training.

PRESIDENT'S LETTER

Some things are forever – even after life

By Arvind K. Goyal, MD



A man knocked at the heavenly gate,
His face was scarred and old.
He stood before the man of fate
For admission to the fold.
"What have you done," Saint Peter asked,
"To gain admission here?"
"I've been a physician, sir," he said,
"For many and many a year."
The pearly gates swung open wide.
Saint Peter touched the bell.
"Come in and choose your harp," he said.
"You've had your share of hell."

– Author unknown

When I read the above poem, I decided to extend it a little for your reading pleasure. So, please go on:

As he walked to do what he was told,
His pager went off: beep, beep, beep.
His heart sank as he realized
He had no coverage for his unscheduled heavenly sleep.

He looked around and begged for mercy,
One phone call was all he needed to make.
"My service needs to hear from me, please, please, somebody,
"Save me the trouble, for heaven's sake."

Nothing would calm him down, however hard an angel tried.
"Nobody is indispensable, nobody takes calls here,
"What could one do by phone, so far away?
"Illinois license expires when you do, just forget that career."

The good ex-doctor argued, "What if it was a sick patient?
"Or one with pain, hurt, cold or lice,
"Or a new mother calling about her baby's diaper rash,
"Or some worried soul just looking for timely advice?"

And how patients waited for him days, sometimes,
When they knew he was at a convention out of town,
Like the one who waited till his appendix ruptured,
Yet another with a heart attack, who went down.

"Hospital nurses call, too, when patients can't sleep or 'go,'
"I get in a big-time mess if I don't call back in a while.
"It could be my wife calling," was his final plea.
"When I'm late, she loses everything, including her smile."

The angel, exasperated, called in consultants who agreed,
The request was straightforward, simple and pure.
Nobody has phone privileges in heaven, normally,
But this couldn't be ignored, an exception to be sure.

A cellular call was then arranged – first in a million years.
The ex-doctor called his service down on earth, very relieved.
"Insurance reviewer called, why Mrs. Dee is still in hospital."
An urgent call indeed, he understood, and surely believed.



"Our water list, sir. I recommend Delaware River 1937."

GUEST EDITORIAL

Collapsing a convoluted case

By Arvind K. Goyal, MD

In December 1992, the Chicago Tribune *published a letter written by Joseph A. Power Jr., president of the Illinois Trial Lawyers Association. In it, Power took issue with a previously published letter written by ISMS President Arvind K. Goyal, MD, which supported caps on noneconomic damages in malpractice cases. The following is Dr. Goyal's response to Power's letter.*

Contrary to Mr. Joseph A. Power Jr.'s expressed shock in reading my Dec. 3 letter in the *Chicago Tribune*, I was neither shocked nor surprised with his response published Dec. 22, 1992. In his position as president of the Illinois Trial Lawyers Association, Mr. Power is obviously representing those who continue to benefit from serious abuses in our current legal system. The messier that system becomes, the merrier for them!

His convoluted case for the status quo in a legal system that fosters many abuses, while simultaneously calling for "comprehensive health care reform," defies logic and is further evidence of a narrow focus of self-interest. A malpractice situation out of hand is one of the major causes of rising costs for everybody and health care access problems for some.

Illinois physicians believe those truly injured through negligence deserve compensation quickly, fairly and squarely for economic losses including lost wages, past and future medical expenses, etc. Yet the huge, multi-million-dollar awards for such subjective and nonquantifiable items such as pain, suffering, mental anguish, loss of consortium, etc., ought to be capped at a reasonable ceiling.

By Mr. Power's statistics, "malpractice premiums accounted for less than 1 percent of the cost of health care," implying that the amount paid for malpractice insurance is not really that significant. Yet the total U.S. health care bill is over $800 billion this year. One percent of that is $8 billion, a considerable sum of money in most people's opinion. Think of all the good that $8 billion could do for people in need of medical care!

Our court system gets clogged up and takes years to sort through the numerous cases filed, about 75 percent of those without rhyme or reason, which are closed without any awards. Yet those "frivolous" suits need to be defended too – and they too cost significant effort, time taken away from patient care and defense attorneys' fees – all of which go into the equation that raises the cost of health care.

Mr. Power is right when he implies most physicians carry professional liability insurance. But at what cost? In 1992, my patients helped me – as a family practitioner – pay over $17,000 for my insurance coverage. There are other specialists in Chicago and elsewhere in Illinois who pay $80,000 to $100,000 per year!

And then, there is the fear of malpractice, which encourages the practice of "defensive medicine," which benefits nobody, not even plaintiff attorneys, but adds billions to the nation's health care bill.

The number of malpractice suits may have stabilized in Illinois since the reform measures adopted in 1985 and 1987. However, the amounts paid out in each claim have increased steeply. A recent study published in the *Journal of Applied Economics* found that attorneys pursue more medical malpractice claims when their incomes drop. No wonder the few companies still in the business of providing liability insurance coverage for Illinois physicians are required by the state's Department of Insurance to carry big reserves.

Mr. Power stated that the cost of malpractice premiums "has not impaired the income of physicians." This fact provides the best proof of all that the medical profession's advocacy of malpractice reforms is only for the positive effect it will have on reducing the cost of health care eventually paid by our patients.

The 18,000 physician members of the Illinois State Medical Society believe that problems and waste in our health care system, when identified, should be appropriately and effectively addressed. Let there be no doubt, however, that any workable health care reform proposal must include elimination of abuses in our legal system. The greed of a profiting few should not be allowed to deny all our people the opportunity to have an accessible and efficient legal or health care system.

GUEST EDITORIAL

How's that again? Or, read before signing

By Dan Burge, MD

The following "bloopers" are representative specimens extracted from case records brought to the Georgia Medical Care Foundation for review. No record is kept of their respective origins. They are reproduced here as entertainment and also for their "cautionary" value. Most of these were taken from typed histories and physicals, discharge summaries and progress notes that had been signed by their authors. Some were handwritten and signed. If we can sign absurdities such as these, we may also sign misinformation that is not so easily detected as such.

For starters, what do you make of the following?

"Patient became vigorously more unresponsive."

"She is bedridden and is being torn from one side to the other."

"The lab data showed tachycardia."

"Yesterday a CAT scan of her head showed no evidence of a recurrent MI."

"Patient was hemolyzed for 3½ hrs on June 10th."

"The patient continued to be very somatic about her hospital stay."

"The patient was admitted in a grossly inappropriate state."

"According to H&P, this 80-year-old patient has parents, ages 59 and 60, both living and well."

Most of these were taken from typed histories and physicals, discharge summaries and progress notes that had been signed by their authors. Some were handwritten and signed. If we can sign absurdities such as these, we may also sign misinformation that is not so easily detected as such.

The following report gives rise to questions:

"On January 20, the patient was put into a rectal tube." (The record doesn't state when the patient was taken out, nor does it reveal whether this action was regarded as custodial, therapeutic, or punitive.)

In addition to "one liners" we have examples of convoluted prose:

"She describes her discomfort as band-like in description at approximately T4 a retrosternal diaphoresis presyncope with radiation to patient's right arm. The patient reported experiencing one of her stable anginal episodes approximately on the day of presentation."

Or perhaps you would like to wrestle with this one:

"His abdomen shows calcified residua of It. hemothorax or empyema at the left lung base associated with chronic volume loss, otherwise normal abdominal and pelvic CT. I don't know how his chest got mixed up with his pelvis but anyway that's it."

In the "Touching All Bases Department," we find this model of circumspection and circumlocution:

"My impression was an 84-year-old man and findings consistent with ischemic cerebral incident probably related to hypertensive etiology with probable thrombotic overlay. The possibility of embolic phenomena was also to be considered."

In the "Nature's Helper Department" we find:

"At this point his pressure is still fairly high systolic and we need to augment his pressure as best we can."

One patient was referred to as "this poor sole." (Down at the heels perhaps? Or was the writer an ichthyologist?)

In this golden age of euphemism and endlessly elastic definitions we read: "This 40-year-old lady apparently goes by a number of different names. Admitted in custody of the sheriff with a number of charges outstanding. Also has history of elopement from other hospitals. SS and FBI are also involved. 20 threats against the President." (Lady?)

Consider this model of conservative judicial caution:

"Besides other possible potentials..."

We offer in wonderment these startling items:

"Patient lives with his wife from data base."

"Antibiotic not sensitive to this organism."

"Urinalysis revealed multiple orgasms."

"In locomotion she was all total assistance."

"Patient went home and committed suicide again."

"Knee pain is increasing in nature."

From a letter of additional documentation we learn:

"I trained at the Jacksonville Navel Hospital." (The last word in subspecialization?)

In a letter from GMCF to a bewildered attending physician we read:

"Antibiotic therapy was started prior to cultures being done on a draining wound of the patient's urine." (We are all in this together, it seems.)

We shouldn't take all this personally – or should we?

Dr. Burge is associate medical director of the Georgia Medical Care Foundation. This article is reprinted with the permission of the Journal of the Medical Association of Georgia.



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ISMIE Update

Medication mishap seminar planned

PAGE 10

Case in Point: Avoiding prescribing errors

PAGE 10

Learning ways to identify and help impaired physicians

ADVOCACY: The ISMS Physician Assistance Program gets impaired doctors back on the road to productive practice. By Gina Kimmey

[CHICAGO] Like people in all walks of life, physicians face the real and growing problems of substance abuse and psychiatric disorders. The stresses and demands of medical training and practice – together with their ready access to a host of addictive substances – make physicians especially vulnerable to impairment.

Although substance abuse and psychiatric problems are the most common forms of impairment, physicians can also suffer from physical problems caused by illness or accidents, from sexual disorders and from gambling addictions. To help these impaired physicians get back on track, ISMS developed a physician assistance program.

Funded by a grant from the Exchange, the ISMS Physician Assistance Program is contractually administered by Martin Doot, MD, who oversees the program's confidential case management services. Dr. Doot addressed ISMIE underwriters March 19 to explain the program's services, ways to recognize impairment and steps to help impaired physicians return to practice.



Wm. Daniels/The Photo Partners

Dr. Doot addressed ISMIE underwriters March 19, explaining ways to recognize and help impaired physicians.

The program's goal is to motivate impaired physicians to seek evaluation and treatment and return to practicing medicine as quickly as possible. One of the program's most important components is trust.

"Physicians must know and believe that they can trust the system, not because of what the law says, but because they have an advocate in the program. There is someone here who has the same problem, who has been through it," Dr. Doot told the underwriters. Confidentiality is of the utmost importance. The program must obtain a signed release from the physician before any information is provided to anyone, including ISMIE.

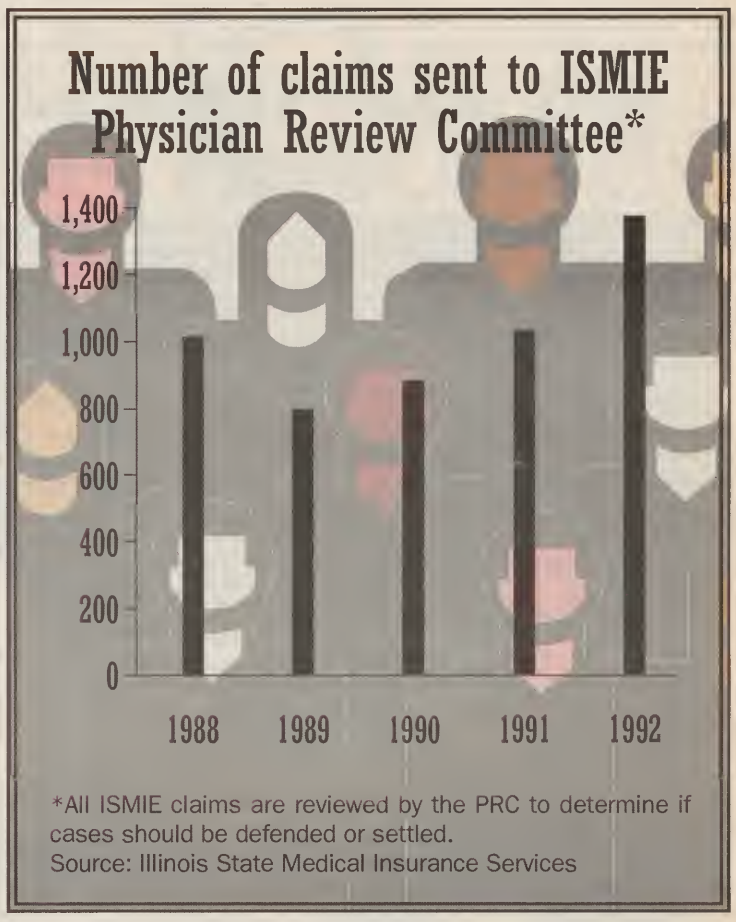
When physicians initially contact ISMIE to apply for malpractice insurance, they complete an application and evaluation process. It is important for all physicians, particularly recovering physicians, to know that this is a routine underwriting process; all physicians are evaluated. Recovering physicians are never refused insurance coverage simply because they were once impaired. When physicians inform ISMIE that they are in recovery, ISMIE evaluates the impairment and confirms that they are receiving treatment and are complying with the treatment conditions. Once insured, recovering physicians assume the responsibility for providing ISMIE with written notification on a regular basis from their treating physician noting their compliance with the treatment regimen. Similarly, ISMIE insureds who admit an impairment problem do not jeopardize their liability coverage solely because of their impairment if they enter a treatment program and participate in an aftercare program to aid their recovery.

By admitting an impairment on license or insurance applications, physicians initiate their recovery. But many impaired physicians live in denial. "The most common forms of denial are minimizing, rationalizing and blaming others," he said. "A physician may say, 'If my department chairman wasn't always putting so much pressure on me, I wouldn't need this drink to relax.'"

PHYSICIANS IN DENIAL may also have an "enabler" – a spouse or colleague who makes excuses and covers up for the impaired doctor. Dr. Doot listed several signs that a physician may be impaired.

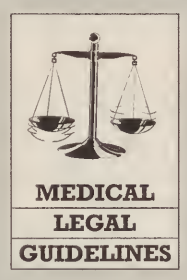
The "practice setting" is usually the last place impairment becomes visible, Dr. Doot explained. Personality and behavioral changes may surface at home before work begins to suffer. Personality changes may include a loss of enthusiasm, a negative or cynical attitude, anger, depression or isolation, he said. Subsequently, the impaired doctor's work habits change and the physician may become careless. Common warning signals include late charting, errors in prescribing medications, poor documentation, missed appointments and complaints from patients. Other signs underwriters should view as red flags are frequent moves

(Continued on page 11)



*All ISMIE claims are reviewed by the PRC to determine if cases should be defended or settled.
Source: Illinois State Medical Insurance Services

Transfer, medical testimony guidelines outlined



Hospital patient transfer guidelines for persons who present themselves at emergency rooms are governed by Section 1867 of the Social Security Act, which bars transfer of patients in an unstable condition or in active labor. The Act requires that a hospital with an emergency department provide for an appropriate medical screening examination to determine whether an emergency medical condition exists or whether the individual is in active labor. Subsequently, the hospital must either provide for further examination and treatment or make the appropriate transfer at the request of the patient (or legally responsible person acting in his or her behalf) or at the direction of the physician (or other qualified medical personnel). In the case of a transfer, the receiving hospital must agree to accept the patient, and have both the space and qualified personnel needed. Other types of transfers, including transfers from and to nursing home facilities, have certain standards, i.e., there are provisions on patient transfer in the Illinois Emergency Medical Care and Trauma Codes. Both federal and state legislation/regulations regarding this topic are in a state of flux and will be outlined when final.

The general guidelines for terminating a physician-patient relationship apply regardless of whether the physician will be paid for services (reference guidelines under Abandonment). The physician should document the steps taken to transfer a patient in the patient's medical record.

ISMS WILL PROVIDE impartial medical evaluators to judges for court cases in Illinois, according to Supreme Court Rule 214. The ISMS Impartial Medical Evaluation Program offers objective medical reports on cases submitted to it by the Industrial Commission and the Circuit Courts.

(Continued on page 11)

Case in Point

Avoiding prescribing errors

By Tony Sullivan

Presenting complaint and initial diagnosis: A 38-year-old woman visited a family physician complaining of nervousness, insomnia and heart palpitations.

The physician had seen the patient on only three previous occasions beginning about three weeks before this visit. On the first visit, the patient complained of a persistent cough, headache, palpitations, insomnia and nervousness, which she attributed to family problems. After diagnosing hypertension, the physician recommended a low-salt diet and prescribed chlordiazepoxide hydrochloride and guaifenesin with dextromethorphan and hydrobromide.



The case in brief: Shortly after the office visit, the patient's pharmacy contacted the physician for authorization to refill prescriptions for theophylline anhydrous and albuterol, which her former physician had prescribed. The physician authorized the refill.

Two weeks later, the physician saw the patient again for treatment of the same complaints. He conducted a physical examination and noted elevated blood pressure, irregular pulse rate and tremors in both hands. A cardiac examination revealed tachycardia. The physician recommended the patient admit herself to the hospital for further testing, but she refused, citing personal problems. The physician prescribed hydrochlorothiazide, methyldopa and propranolol hydrochloride. Propranolol hydrochloride and methyldopa were prescribed for treatment of suspected hypertension. Later that evening, a local hospital informed the physician that the patient had been brought to the emergency room and pronounced dead on arrival. The cause of death was determined to be propranolol hydrochloride-induced status asthmaticus.

The resulting claim: The patient's family sued the physician for his alleged improper prescription of propranolol hydrochloride to the patient, who had asthma, and for her resulting death.

The outcome of the claim: The claim was settled for $1.7 million.

The points this case makes: One of the most common causes of suits arising from medication errors is failure to obtain an adequate medication history and to document current medication use in the patient's chart, said Vasanth M. Surath, MD, a Chicago internist and a member of the Exchange's Risk Management Committee.

Lawsuits resulting from medication errors are among the most costly closed claims faced by the Exchange. Since 1985, 27 percent of all medication-error claims closed have been closed with indemnity, but only 20 percent of all claims closed have been closed with indemnity. Of all Exchange claims closed with indemnity since 1985, 9 percent were related to medication errors.

"This case is a classic example of that error," said Dr. Surath. "It is critical that physicians check the patient's current medication usage and condition before prescribing additional medication, so that potential allergic reactions, side effects and drug interactions can be properly assessed."

IN THIS CASE, the attending physician failed to realize that the patient had asthma and then prescribed propranolol hydrochloride, a beta blocker, which is widely documented as being contraindicated in patients with asthma, Dr. Surath noted. Compounding the physician's improper treatment was the fact that he had at least three opportunities to learn the patient's condition through fundamental patient care.

The asthmatic condition should have surfaced during thorough history taking on the first visit. The physician should have requested and thoroughly reviewed the patient's medical records from her former physician, which also should have revealed asthma. In addition, the physician failed to document the pharmacy's over-the-phone request for authorization to refill prescriptions for theophylline anhydrous and albuterol. This lack of documentation contributed to the physician's failure to link the drugs, which together constitute a common treatment regimen for asthma, with the patient's asthma.

It is crucial to take a thorough history for all patients, particularly the elderly, who may have varying degrees of dementia, and those presenting with emotional problems, such as the patient in this case, Dr. Surath said. Emotional problems may overshadow any physical problems and may affect patients' abilities to accurately and realistically communicate their medical histories to physicians. When treating elderly or emotionally troubled patients, physicians should, when possible, involve a family member in history taking.

Physicians also should question these patients about current medications – particularly maintenance medications – and those that other physicians or health care providers may have prescribed.

"Some patients may have been taking medications for so long – certain thyroid medications and vitamins, for example – that they no longer consider them to be medications," Dr. Surath noted. "These things have to be rather exhaustively questioned by family practitioners and internists who are trying to treat a major illness like hypertension or heart disease."

The same often holds true for patients taking over-the-counter drugs and birth control pills, Dr. Surath said. Women who take birth control pills often don't view them as medications, so when they are asked about current medications, they fail to mention them.

James J. Stamos, a malpractice defense attorney with Stamos & Trucco in Chicago, believes that the patient's emotional state may have contributed to the physician's alleged improper actions. "This sounds like a doctor who didn't take the case seriously because the woman had emotional problems," he said. "When someone presents with emotional problems, I think there are times when doctors take that situation somewhat less seriously. They look at it less as a medical problem than they do as an emotional problem. And as a result, they don't pay enough attention to the medical details of the case."

POOR DOCUMENTATION also contributed to the adverse event, Stamos noted. This negligence can contribute to adverse events in patient care and can significantly weaken an attorney's ability to defend a malpractice case.

"From a defense attorney's perspective, the most likely source of trouble in the evidence is the office notes," Stamos said. "Typically, they don't say enough. Often, while we firmly believe that our doctor said X, did Y or heard Z, the records don't show it."

Dr. Surath and Stamos offer these suggestions to reduce adverse events:

- Control the inventory of medication samples provided by detail people from pharmaceutical companies. Physicians' supplies of sample medications can quickly get out of control and can put them at risk for giving away dated medications or new medications with which they aren't really familiar.
- Make it standard practice to ask new patients to bring their current medications on first visits and to ask them why they are taking them. Document their responses.
- Place a medication flow chart in a prominent spot in the patient's chart to monitor the medication regimen and avoid prescribing contraindicated medications or two or more medications whose interactions may cause injury.
- Identify patients with allergies by placing colored stickers prominently on their charts and medication flow sheets. ■

Case in Point is a regular feature using hypothetical case histories to illustrate loss-prevention maxims.

Exchange plans medication mishap seminar

Physicians can learn how to minimize their risk of lawsuits arising from alleged misuse of medications at a May seminar sponsored by the Exchange. "Medication Mishaps: Causes and Prevention" will be held May 19 at the Hyatt Regency Hotel in Chicago and May 20 at the Hilton Hotel in Springfield. The four-hour program, planned by the Exchange Risk Management Committee, is designed to help physicians avoid common medication prescribing and administration errors that could expose them to potential liability. For more information about the program, contact the Exchange risk management department at (312) 782-2749 or (800) 782-ISMS. ■

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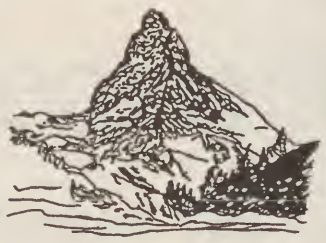
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Impaired physicians

(Continued from page 9)

or job changes in a short period of time, Dr. Doot said. A combination of several of these characteristics strongly indicates a potential problem, he said.

The Physician Assistance Program is a recovery process, not a disciplinary process. When physicians call the assistance program about their impairment, their call receives immediate attention. But if they are referred by family or friends, the program's first step is an investigation to confirm the suspected impairment. Physicians are always notified of the investigation, Dr. Doot said. An evaluator talks to family, friends and colleagues – all with the doctors' permission – to determine whether an intervention is needed. Physicians' withholding permission for evaluators to talk to family or colleagues may indicate that something is wrong.

When indicated, an intervention is typically conducted in a home or at the physician's office or hospital. The physician is confronted by a group of people, including trained intervenors and concerned family members and colleagues who care about the doctor's recovery. If the intervention is successful, the physician becomes motivated and willing to begin treatment. The Physician Assistance Program does not provide treatment; instead the physician is referred to an effective, experienced evaluation and treatment program, Dr. Doot said.

AFTER TREATMENT, recovering physicians are asked to sign an "aftercare" agreement. Agreements vary slightly depending on the type of impairment but generally state that the physician agrees to continue care and cooperate with monitoring for at least two years, or more if necessary.

Monitoring may include continuing treatment, attending self-help groups and/or undergoing toxicology testing of body fluids.

"The keys to a successful aftercare program are continuity and a monitor who can tune into relapse symptoms before the physician ever even engages in his or her impairment, and who will intervene before anything happens," said Dr. Doot.

The program's final step is advocacy. Physicians meeting all the requirements of the aftercare agreement are offered advocacy services by the Physician Assistance Program to support their reentry into practice in recovering status. Dr. Doot emphasized the program is not intended to expose or punish impaired doctors but to help them overcome their impairment, and return to practice and regain their status as respected members of the medical community. "This is the main purpose of the program. Doctors who are compliant and recovering can continue practicing medicine and say, 'I belong.'"

Individuals may contact the program 24 hours a day by calling the Physician HELPline at (312) 580-2499. All information is strictly confidential. ■

Guidelines

(Continued from page 9)

When the courts need an impartial evaluation on a particular case, they notify ISMS. A physician in the appropriate specialty who is located in the appropriate geographic area is chosen from the pool to be the Impartial Evaluator, and ISMS will set up an appointment time between the patient and the physician. The courts are then notified, and they send any pertinent records or previous history on the patient to the physician. They in turn notify the patient's attorney. The evaluator performs the examination, writes a report, and sends it to the courts. He or she is reimbursed for his or her usual and customary charge for the procedure by the requesting agency for the services provided. A minimal number of evaluators may have to testify in court.

In order to participate as an Impartial Evaluator, the physician must be an ISMS member in good standing. It should be noted that although the doctrine of public official immunity exists, the same may not be seen to afford absolute immunity to a physician-evaluator. An evaluator can be viewed as a public official due to the fact that he or she is appointed by the court to provide an independent evaluation in order to provide the court with assistance. However, since the evaluator is also a physician, the physician owes the same duty of care to this patient as he or she does to any other. If a physician-evaluator breaches a duty which is owed all his or her patients, he or she may be held liable, despite his or her court appointed status (*Madden vs. Kuehn*, 56 Ill. App.3d 997, 372 N.E.2d 1131 (2nd Dist. 1978)). ■

Editor's note: This is part of a series covering medical-legal issues written by the ISMS Medical Legal Council. ISMS policy may not be represented in the medical legal guidelines. The information addresses legal concerns that physicians most commonly express to ISMS. It is intended to serve only as a general guide for physicians, not as specific legal advice.

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EMOTIONAL

Detecting the signs of

Family physicians and internists who ask open-e
can help iden

BY STACI

The clues may be as simple as a patient's insomnia or loss of appetite, but they may point to a condition as complex as depression or an anxiety disorder.

"The prevalence of depression or anxiety disorder in patients, based on many studies, averages about one in five," said P.S. Sarma, MD, a child psychiatrist and chairman of the ISMS Council on Mental Health and Addiction. "Though about half of those patients will not be affected to a disabling degree, the problem may still be there, having impact on the patient's health and well-being."

Patients may be suffering the stress of a traumatic event or a life or relationship change, Dr. Sarma noted. Or they may be experiencing depression, anxiety disorder or psychosis. The key for the family physician is to detect the signs, ask questions and intervene.

"Right now, roughly a third of patients who walk into a physician's office and have a psychological disturbance are identified, referred and treated," said Dr. Sarma. "That means that two out of three are missed. Their physician didn't ask questions that would have helped unearth the signs of a problem.

"Physicians may be so used to focusing on a patient's physical symptoms," he added, "but those symptoms can be just the tip of the iceberg."

Robert C. Powell, MD, a Chicago-area psychiatrist, noted that depression can be difficult to detect.

"Family doctors are on the front lines and need to watch for certain problems," said Dr. Powell, president-elect of the Illinois Psychiatric Society. "If a physician hears from a patient that he or she has trouble sleeping or is experiencing sadness, the time to react is right away."

Depressed patients often awaken for no apparent reason within two hours of falling asleep, Dr. Powell said. When they awaken, they may immediately feel anxiety, fear or dread, or they may experience a knotting or churning stomach. Patients with these serious symptoms should be referred for psychiatric care, Dr. Powell recommended.

"There are many kinds of depression," Dr. Powell said. "Depression can be related to seasonal changes, neurological problems, even alcohol addiction. I always recommend to my internist colleagues that if the patient doesn't respond to treatment for depression right away, the patient needs to be referred for specialized care." Some depressions can be biological and hereditary and should be treated by psychiatrists trained to diagnose and care for these conditions, Dr. Powell noted.

According to the National Institutes of Health, occurrence of major depression in women peaks at about age 45 and then drops. In men, incidence peaks at age 30, remains high through age 40, drops and peaks again at age 60.

When caught early, depression is one of the most treatable mental illnesses, according to the American Psychiatric Association. Eighty percent to 90 percent

How well do you know phobias?

Millions of Americans are afflicted with phobias or panic disorder, according to the National Institute of Mental Health. These conditions are marked not only by great anxiety in relatively safe situations, but also by an exaggerated avoidance of the source of distress. Whether phobias cause depression or depression causes phobias is unknown.

Some phobias are better known than others. To test your knowledge, match the phobia in the left-hand column with the definition in the right-hand column. Answers are given below.

1. Gatophobia	a. Fear of moving or making changes
2. Sciophobia	b. Fear of lightning
3. Tropophobia	c. Fear of crowds
4. Triskaidekaphobia	d. Fear of failure
5. Astrapophobia	e. Fear of crossing bridges
6. Gephyrophobia	f. Fear of shadows
7. Ochlophobia	g. Fear of the number 13
8. Kakorraphiaphobia	h. Fear of cats

Source: National Institute of Mental Health

1. h; 2. f; 3. a; 4. g; 5. b; 6. e; 7. c; 8. d.

SORDERS

epression and anxiety

*d questions and listen carefully to the answers
f problems.*

ROZIER

of depressed patients respond to treatment that includes medication, psychotherapy or both, APA said.



Rob Barber

ANXIETY DISORDERS can be tough to identify as well. Patients may think of a phobia as trivial or ridiculous and even try to hide such symptoms as stomach pain, rapid heartbeat or high blood pressure. Patients who suffer panic attacks often have more trouble hiding their symptoms, but their feelings of panic and of being in imminent danger, which occur unpredictably, can keep them from participating in normal activities.

Physicians who see patients with unexplainable high blood pressure, skin rash, tics, tooth grinding, headaches or muscle aches, for instance, should ask open-ended questions to draw their patients out, said Dr. Sarma.

"Physicians should be asking questions like, 'Tell me what you're worried about,' or 'What kinds of stress are you experiencing right now?' Questions like these are helpful in eliciting information about symptoms you might not detect."

If a patient does describe symptoms of depression or anxiety disorder, the next step is to set up another time to talk about the problem, said Dr. Sarma.

"Taking extra time to really talk to the patient and to listen to how he or she is feeling will help the physician decide how the problem should be addressed," continued Dr. Sarma. "If the problem seems stress-related or very minor, the patient may find relief just from receiving the support of the physician. When a physician finds evidence of a more long-term or serious problem, the patient needs and deserves to be referred for psychiatric care."

Physicians also may notice symptoms of depression or anxiety in their critically or chronically ill patients because these patients are at higher risk.

Studies have shown that patients with chronic diseases are more vulnerable to depression. This can lead to problems ranging from complications caused by noncompliance with treatments to a higher mortality rate than that of their nondepressed counterparts.

MEMBERS OF THE general population affected by depression or anxiety disorder could include people as diverse as a young teenager struggling with the pressures of parental and peer expectations, a middle-aged patient experiencing job or relationship stresses, or a patient paralyzed by a phobia, said Dr. Sarma.

"Any symptom that has an impact on how the individual functions is a potential problem," said Dr. Sarma. "Any of our patients could be at risk. We need to ask the right questions, identify problems and set a course for treating the whole patient." ■

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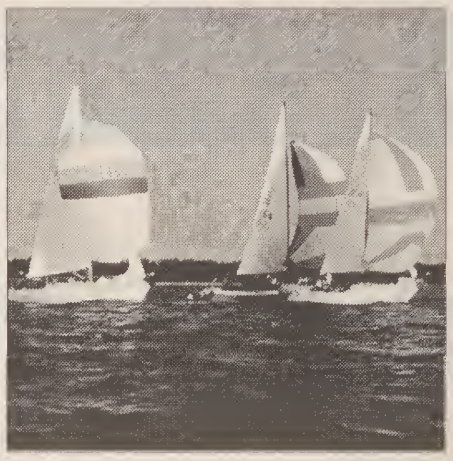
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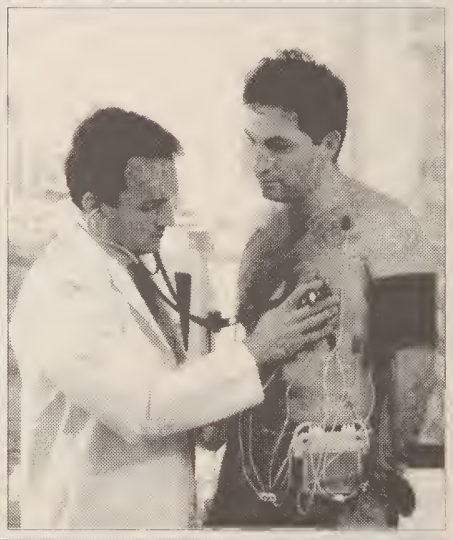
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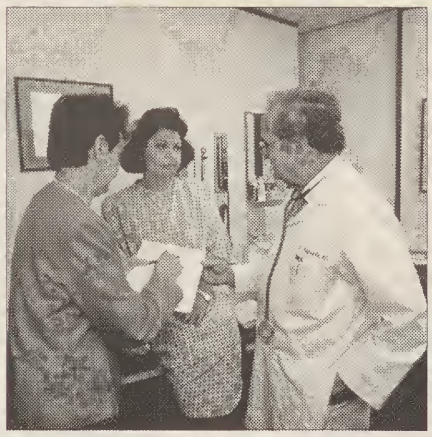
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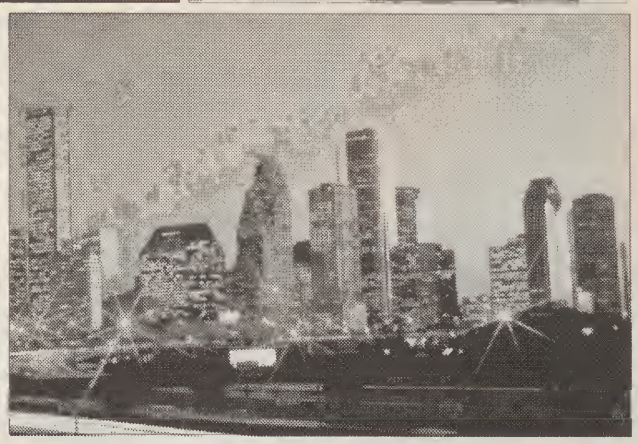
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ISMS prepares for 1993 Annual Meeting

House of Delegates business sessions, an educational seminar and a physician talent show will highlight this year's gathering. By Kevin O'Brien



Returning for the second year to the Oak Brook Hills Hotel in Oak Brook, ISMS trustees, delegates and alternate delegates will gather from Friday, April 23, through Sunday, April 25, to deliberate the fate of 84 resolutions.

Consideration of the resolutions in five reference committees is scheduled to begin at 1:30 p.m. Friday. As in past years, any ISMS member – delegate or not – may attend and testify at the reference committees. A special presentation regarding ISMS financial statements will be held at 1 p.m. in Reference Committee A.

Reflecting the probability that 1993 will be the year of federally mandated health care system reform, this topic drew more resolutions than any other. The House of Delegates will debate at least 18 reform-related resolutions, including one from the ISMS Board of Trustees.

SAYING IT BELIEVES THAT ISMS' 10 Health Care Reform Principles adopted by last year's House "should be enhanced and amplified," the board is offering a resolution to amend the commentary on the principles. The proposed additional language expands and clarifies the ISMS position on equal access to basic health care services, including preventive care, for all citizens. The resolution also includes language clarifying the ISMS positions on community rating, preexisting condition limitations and ways to foster competition among health insurers.

Two resolutions take opposite positions on what informed sources have indicated will likely be the fundamental proposal of Hillary Rodham Clinton's Task Force on National Health Care Reform, namely, establishing some form of managed competition. One resolution asks the House to simply "condemn the concept of managed competition," while the other urges ISMS to "proceed to establish ... a physician-owned and sponsored entity to initiate managed care contracts with business, government, insurance and hospitals on behalf of physicians and patients."

Other delegates are offering resolutions to establish individual medical savings accounts, a "basic health care board" to determine what constitutes basic coverage, a universal health care system modeled on the existing Medicare program and "concurrent reform of the insurance industry."

UNIFIED MEMBERSHIP makes a return visit to the House agenda with two resolutions. One asks the House to remove mandatory AMA membership as a condition of ISMS membership. The other, noting the "marked differences of opinion" on this issue, suggests that ISMS poll the membership and make the results available to the delegates at the 1994 Annual Meeting, if the issue arises again.

Several public policy issues affecting physicians are also back from previous years' House agendas. Building on the prohibition against physicians' self-referral of patients to facilities in which they have a financial interest, one delegate advocates that the AMA broaden its ethical code "to prohibit all financially motivated physician referrals, including those involving gatekeeper primary care physicians and managed care organizations." The issue of physician participation in state executions is reflected in a resolution asking the House to endorse the statement that the "presence of a physician at an execution is in no way unethical." And the National Practitioner Data Bank comes under attack again this year with a new resolution calling on the AMA to work "in a timely manner to dismantle" the Data Bank.

Delegates will vote on the resolutions during Saturday's House session and again on Sunday morning. Immediately following the Saturday afternoon session, AMA Board Chairman Raymond Scalettar, MD, will present the program "AMA Perspectives on Healthcare." Dr. Scalettar, a Washington, D.C., internist, will discuss the Clinton administration's effort to develop a reform package for congressional action later this year. Dr. Scalettar will also answer questions from the delegates.

> *Taking a break from business, delegates Friday evening will be entertained by fellow physicians and their families during the annual President's Night reception.*

On Saturday, Arvind K. Goyal, MD, will address the House as ISMS president for the final time. ISMS President-elect Arthur R. Traugott, MD, of Urbana, will be sworn in as the Society's president on Sunday morning and will outline his plans for his year as spokesperson for the 18,000 physician members of ISMS. Before its scheduled adjournment on Sunday, the House will elect ISMS officers, trustees and delegates to the AMA to serve for the coming year.

TAKING A BREAK FROM BUSINESS, delegates Friday evening will be entertained by fellow physicians and their families during the annual President's Night reception and dinner honoring Dr. Goyal, of Rolling Meadows. Dr. Goyal invited those members who were "willing and able to sing, play, dance, talk or do something else for fun that night" to volunteer in lieu of "brand name" entertainment.

Meanwhile the ISMS Auxiliary will celebrate its 65th year at its April 21-23 annual meeting "A History of Progress." The April 22 keynote speaker will be AMA Auxiliary President-elect Mary Hanson of Colorado, and therapist Esther Nitzberg, author of *Hippocrates' Handmaidens: Women Married to Physicians*, will address the auxilians on the stresses of medical marriages.

On Friday, ISMS Auxiliary President Carol Gapsis of Effingham will present her final report to the Auxiliary, after which auxilians will hear a legislative update on the Washington scene by Mary Lukens of Coldwater Corp. In the afternoon, Hanson will officiate at the installation of incoming ISMS Auxiliary President Mindy Chadwick of Decatur and other Auxiliary officers. ■

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Illinois law and financial planning

By David N. Barkhausen

Three financial planning options governed by three Illinois statutes – two of them relatively new – provide simple and effective ways to protect assets. Each option presupposes a desire to maximize ownership and control of the assets to be protected.

TENANCY BY THE ENTIRETIES is a new means for spouses to own their marital residence. It was enacted by the Illinois General Assembly in 1990, primarily to prevent spouses in a deteriorating marriage from conveying or mortgaging the one-half interest in their home without the consent of the other spouse.

Similar to the most common form of ownership – joint tenancy with right of survivorship – tenancy by the entireties differs in its impact on creditors' rights. With joint tenancy, each spouse's half interest can be attached by joint creditors of one or both spouses, but a marital residence owned in tenancy by the entireties is not subject to a claim by a creditor of only one of the spouses.

This additional protection is provided by a simple deed, signed by the owners, reconveying their marital residence to themselves as tenants by the entireties, and recorded with the Recorder of Deeds.

A LAW PASSED by the General Assembly in 1989 with the active support of ISMS shields assets in retirement plans. It further creates a conclusive presumption that such a plan is a "spendthrift trust" under Illinois law, effectively protecting qualified plan assets from creditors in bankruptcy.

As defined by this Illinois statute, retirement plans permit both the participant's and employer's contributions to be made on a pre-tax basis, through instruments such as IRAs, including self-employed person IRAs, Keogh plans for owners of businesses and partners in a professional practice, and defined benefit plans.

The additional provision in the Illinois law creating a conclusive presumption that a qualified plan is a spendthrift trust (the proceeds of which cannot be reached by creditors) has been the basis for several rulings that a debtor's interest in a retirement plan can be excluded from the bankruptcy estate. More complete assurance of protection has now been provided by the U.S. Supreme Court in its June 1992 decision in *Patterson vs. Shumate.*

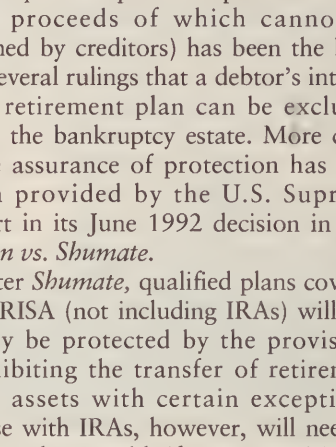
After *Shumate,* qualified plans covered by ERISA (not including IRAs) will certainly be protected by the provisions prohibiting the transfer of retirement plan assets with certain exceptions. Those with IRAs, however, will need to rely on the spendthrift trust provision of Illinois law.

For now, in Illinois, all retirement plan assets are protected if the participants have discharged their debts through bankruptcy.

THE BENEFITS OF cash value life insurance and annuities are less well known. Under Illinois law since 1973 and under the laws of many other states, life insurance proceeds and the cash value of life insurance and annuity contracts have been protected from creditors of the insured (other than the IRS) when the spouse of the insured or other dependents are beneficiaries. This exemption applies even when the insured has retained the right to change the beneficiary or when the insured's estate is a contingent beneficiary. This special treatment for cash value life insurance is an additional argument for whole life as opposed to term insurance.

Most financial planners generally agree that for those who need life insurance protection for 12 years or more and can afford the higher premiums of permanent insurance, whole life, with a top-rated insurer, makes more sense than term coverage. In Illinois, the cash value in a life insurance policy is also beyond

(Continued on page 23)



David N. Barkhausen, JD, *is an agent with Northwestern Mutual Life and an investment officer with Robert W. Baird, Inc., which has offices in Lake Forest and Chicago. He is also Republican state senator from Lake Bluff.*

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3-oz. cooked serving of chicken breast

Best of pork



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Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

Compare pork with chicken[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz, cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.[1] According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products,* 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products,* 1979. Agricultural handbook 8-5.

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Illinois fares well in match

PRIMARY CARE GAINS: Match results for 1993 show improvement for many Illinois medical residency programs. By Karen Sandrick

[EVANSTON] Across the country and the state of Illinois, family practice posted impressive gains in the 1993 match for first-year medical residency slots.

According to the National Resident Matching Program, more than 77 percent of the 2,589 family practice residency positions were filled nationwide, 10 percent more than last year.

Family practice residency programs throughout the state also report significant improvement. "Normally, the Chicago programs do relatively well, but this year things were better from the family practice perspective, pretty much statewide," said David C. Garretson, DO, member of the ISMS Council on Education and Manpower.

"Some community-based family practice programs downstate, such as those in Carbondale and Quincy, filled this year, which is something they haven't done for a few years. Some programs that didn't fill any slots last year were able to fill all or most of their positions this year," added Dr. Garretson, a Belleville family physician.

Some community-based family practice programs downstate, such as those in Carbondale and Quincy, filled this year, which is something they haven't done for a few years.

Only two years old, the University of Illinois College of Medicine Family Practice Residency Program at Champaign-Urbana matched three of four positions. In addition, there were more top-notch applicants for the residencies, said administrator Deborah Rugg.

The Belleville Family Practice Residency Program filled its minimum of four residency positions, three directly through the match. "We also interviewed more people this year than we had in past years," noted Dr. Garretson, a faculty member.

OTHER ILLINOIS primary care specialty programs fared well in the match. The Internal Medicine Residency Program at the University of Illinois "matched completely this year, just as we did last year, and we matched with the top 20 percent of our choices," said Deborah Smith, administrator.

Chicago's St. Joseph Hospital filled all 26 slots in its internal medicine program, many with first-rate international medical graduates, said Serafino Garella, MD, chairman of the program.

Northwestern University's McGaw Medical Center matched all but four of its more than 180 residency positions, filling 40 to 50 slots in internal medicine and 30 to 40 positions in general pediatrics, said Robert M. Vanecko, MD, of Chicago, a thoracic surgeon and board consultant to the ISMS Council on

(Continued on page 21)

Percentage of primary care residency positions filled in Illinois

	1988	1989	1990	1991	1992
Family practice	70.3	72.1	54.5	55.5	60.1
Internal medicine	82.5	73.1	76.7	77.1	88.1
Pediatrics	69.7	83.3	77.9	67.3	82.5

Source: National Resident Matching Program

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IMPAC annual meeting set

The annual meeting of the ISMS Political Action Committee (IMPAC) will take place Friday, April 23, at the Oak Brook Hills Hotel in Court G. The meeting, open to all IMPAC members, will convene immediately following the ISMS House of Delegates' morning session.

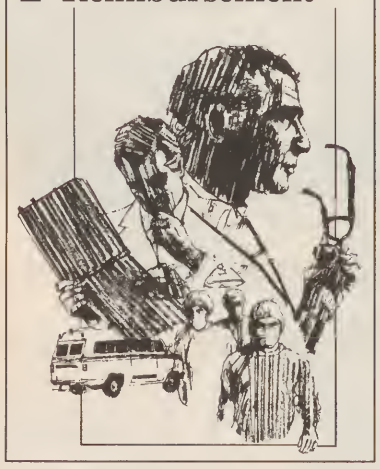
Business will include election of IMPAC Council members. Nominees for appointment or reappointment to the council are:

James H. Andersen, MD, Oak Brook
Andrew M. Basile, DO, River Grove
James A. Bull, MD, Silvis
Alfred J. Clementi, MD
Arlington Heights
Arvind K. Goyal, MD
Rolling Meadows
Albert W. Ray Jr., MD, Joliet
Biswamay Ray, MD, Oak Brook
Marsha G. Ryan, MD, Carbondale
Arthur R. Traugott, MD, Urbana
Jerome S. Weiskopf, MD, Rockford

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OBITUARIES

* indicates ISMS member
** indicates member of ISMS Fifty Year Club

****Bennin**
Morris D. Bennin, MD, an ophthalmologist from Chicago, died Dec. 23, 1992, at the age of 84. Dr. Bennin was a 1942 graduate of Chicago Medical School.

****Bleier**
Robert S. Bleier, MD, an occupational medicine specialist from Northbrook, died Jan. 2, 1993, at the age of 77. Dr. Bleier was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

****Dresner**
Milton H. Dresner, MD, an obstetrician/gynecologist from Northbrook, died Dec. 16, 1992, at the age of 83. Dr. Dresner was a 1937 graduate of Northwestern University Medical School, Chicago.

***Gokoo**
Federico L. Gokoo, MD, a general practitioner from Cornell, died Dec. 19, 1992, at the age of 70. Dr. Gokoo was a 1950 graduate of the Faculty of Medicine and Surgery, University of Santo Tomas, Manila, Philippines.

***Jacobson**
Burton M. Jacobson, MD, an internist from Wilmette, died Dec. 22, 1992, at the age of 67. Dr. Jacobson was a 1950 graduate of the University of Illinois College of Medicine, Chicago.

****Levin**
Harry Levin, MD, an internist from Chicago, died Dec. 23, 1992, at the age of 82. Dr. Levin was a 1936 graduate of Northwestern University Medical School, Chicago.

****Marshall**
William A. Marshall, MD, an internist from Chicago, died Nov. 21, 1992, at the age of 96. Dr. Marshall was a 1922 graduate of Friedrich-Wilhelms Universitaet Medizinische Fakultaet, Berlin, Germany.

****Mehlman**
Jerome S. Mehlman, MD, an internist from Chicago, died Nov. 19, 1992, at the age of 79. Dr. Mehlman was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

****Miller**
Wilbur A. Miller, MD, a general practitioner from Davenport, Iowa, died Dec. 29, 1992, at the age of 88. Dr. Miller was a 1929 graduate of the University of Iowa College of Medicine, Iowa City.

***Mrazek**
Rudolph G. Mrazek Jr., MD, a surgeon from Riverside, died Dec. 1, 1992, at the age of 70. Dr. Mrazek was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

***Nabolotny**
Michael Nabolotny, MD, of Venice, Fla. (formerly of Skokie), died Dec. 25, 1992, at the age of 80. Dr. Nabolotny was a 1945 graduate of Charles Univerzita Fakulta of Ped-Gen Medicine, Prague, Czechoslovakia.

****Nigro**
Dominic Nigro, MD, a general practitioner from Winfield, died Dec. 29, 1992, at the age of 83. Dr. Nigro was a 1933 graduate of Loyola University Stritch School of Medicine, Maywood.

****Parsons**
Harold H. Parsons, MD, a general practitioner from Moline, died Dec. 12, 1992, at the age of 89. Dr. Parsons was a 1929 graduate of Rush Medical College, Chicago.

***Pastnack**
George L. Pastnack, MD, a surgeon from Des Plaines, died Dec. 24, 1992, at the age of 75. Dr. Pastnack was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

****Rubin**
Harry B. Rubin, MD, of Laguna Hills, Calif. (formerly of Oak Lawn), died Dec. 13, 1992, at the age of 86. Dr. Rubin was a 1935 graduate of Chicago Medical School.

****Scannell**
Margaret M. Scannell, MD, a pediatrician from Chicago, died Dec. 2, 1992, at the age of 80. Dr. Scannell was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

***Santinello**
Nello Santinello, MD, an anesthesiologist from Chicago, died Dec. 5, 1992, at the age of 71. Dr. Santinello was a 1948 graduate of Facolta di Medicina e Chirurgia dell'Universita di Parma, Parma, Italy.

***Shipman**
Gregory F. Shipman, MD, a medical oncologist from Chicago, died Dec. 12, 1992, at the age of 41. Dr. Shipman was a 1976 graduate of the University of Minnesota Medical School, Minneapolis, Minn.

Tomovich
Rajko Tomovich, MD, of Chicago, died Nov. 10, 1992, at the age of 72. Dr. Tomovich was a 1952 graduate of Medizinische Fakultaet der Johann Wolfgang Goethe Universitaet, Frankfurt-am-Main, Hessen, Germany.

****Walker**
James S. Walker, MD, an otolaryngologist from Urbana, died Dec. 9, 1992, at the age of 76. Dr. Walker was a 1939 graduate of Indiana University School of Medicine, Indianapolis.

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In addition, ISMS President Arvind K. Goyal, MD, is available for membership calls the first Wednesday of every month, 11 a.m. to noon. Use the toll-free or Chicago number above and ask for ext. 1333. ■

Caps legislation

(Continued from page 1)

makers and to the public," he said. "Illinois physicians need to be involved in the process by supporting tort reform measures and contacting their legislators."

Being sued is "not an indicator of incompetence," Dr. Goyal said in written testimony. "In fact, the very best doctors – often those involved in high-risk, complex medical cases – are more apt to be sued in these days of high medical expectations."

In testimony in the Senate committee, Dr. Goyal and ISMS legal counsel Saul Morse explained the merits of capping large noneconomic awards. "The problem lies in trying to quantify pain, mental anguish and time away from family," Dr. Goyal said. Part of the solution to containing health care costs is to cap "lottery awards that rein money away from health care."

Proponents of S.B. 344 include the Illinois Hospital Association, the American Insurance Association, the Illinois Manufacturers Association, the Illinois Municipal League and Monsanto Company. Its opponents include the Coalition for Consumer Rights, the Illinois AFL-CIO, Illinois Public Action, the Illinois State Bar Association and the Illinois Trial Lawyers Association.

Joseph A. Power Jr., president of the Illinois Trial Lawyers Association, spoke in opposition to S.B. 344. Power appealed to the sentiments of committee members by giving examples of catastrophically injured plaintiffs, but was unsuccessful in convincing a majority of his position. He also posited that each ISMIE policyholder received a $10,000 dividend last year, helping to counteract the high malpractice insurance premiums needed to create sufficient reserves to pay multi-million-dollar verdicts. That figure is inaccurate, since the average dividend the Exchange paid to policyholders was about $200 in both 1990 and 1991. The dividends were distributed annually among 6,000-7,000 qualifying policyholders who had been continuously insured since 1986.

In his testimony, Dr. Goyal also blasted a new study by the Coalition for Consumer Rights claiming that medical malpractice lawsuits are rare in rural Illinois. The study contends that there is no correlation between medical malpractice suits and the availability of rural physicians, and uses data from allegedly medically underserved counties in Illinois to substantiate its claim. However, the coalition overestimates the number of Illinois counties that have physician shortages and fails to include some counties that do have shortages, thereby skewing the numbers and downplaying the magnitude of the rural health care crisis, according to ISMS analysis of the study. In addition, the study accuses ISMIE of collecting in premiums many times the amount necessary to pay out claims. In reality, ISMIE collects premiums in a given year to pay claims filed that year, which may be paid out over a number of years. Payouts seldom occur in the same year the suit is filed. In fact, a recent insurance department audit of the Exchange found that its reserves were neither too high nor too low.

In written testimony, Dr. Goyal referred to a 1987 ISMS members survey that found that 8 percent of respondents had moved their practices to avoid litigation or had completely stopped practicing medicine. Another study found that hospitals in 13 southern counties had closed their obstetrical units because no physicians in the community would deliver babies. "It's time to put patients first in health care reform," Dr. Goyal said. "Restoring fairness and stability in the medical malpractice system will assure all patients access to quality health care in the future." ■

Illinois match

(Continued from page 17)

Education and Manpower.

Southern Illinois University School of Medicine reported that 21.1 percent of its 1993 candidates matched in family practice and 18.3 percent matched in internal medicine.

Preliminary results show the University of Illinois "had three times more application requests for internal medicine than we've ever had, which has to do with a growing market in primary care," Smith said.

However, Margaret McLaughlin, MD, assistant dean of the Medical Student Program, Rush Medical College, Chicago, said she is not sure the match numbers reflect more interest in primary care. "You don't know what students ultimately are going to do. If students who apply to an internal medicine or pediatrics residency go into a pediatric or internal medicine subspecialty, you can't classify them as primary care. So this question ultimately is not answered until three years down the road."

Overall, the picture for primary care, especially family practice, appears brighter. Interviews conducted over the last few years by the Illinois Academy of Family Physicians show increasing numbers of first- and second-year medical students are heading toward primary care. As a result, IAFP contended the 1991 match, in which only 55.5 percent of family practice slots were filled, was the bottom of the downward slide.

"IAFP felt that 1992 would show a slow recovery and that we would start to see fairly large numbers of people getting back into family practice and primary care this year and next year," Dr. Garretson said.

ISMS House of Delegates policy endorses the concept of preceptorships and primary care rotations in health manpower shortage areas. The Society also supports continued state funding for primary care graduate medical education.

The 1993 Illinois match appears to show progress in increasing primary care specialists. "It looks like the percentage of folks going into family practice increased this year; we hope this continues," Dr. Garretson said. ■



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Universal health bill

(Continued from page 1)

both are "government-run and government-controlled programs." The study commission would comprise equal numbers of Democrats and Republicans – a sure indication that more health care reform gridlock is ahead, he said. Also, physicians would be underrepresented among other health care professionals on the commission.

"There are many diverse proposals to reform the health care system," Dr. Goyal continued. "Why should the legislature be forced to choose between two narrowly defined similar alternative experiments – essentially no choice – when there are many positive options, both statewide and nationwide, to improve the current health care system?"

ALTHOUGH ISMS SUPPORTS universal access to health care for all Illinoisans, the Society strongly opposes this legislation, which, if enacted, would be cost-prohibitive because it would be funded by huge tax increases and possibly benefit cuts. In addition, the bill calls for regulations like capital expenditures and global budgets. Calling regulations specified in the bill the "heavy hand of government," Dr. Goyal urged Illinois physicians to contact their legislators and voice their opposition to the bill.

"If this bill passes as proposed, health care costs will soar and rationing will be imminent," Dr. Goyal said. "Although our current system is not without fault, it has provided the best care in the world to millions of patients for decades. It would be a horrible mistake to scrap it for a system that would ration care and stifle medical technology."

The legislation passed out of committee with an entirely partisan vote, with Republicans voting in opposition to H.B. 1459. Without at least a few committee Democrats opposing the bill, it had little chance of being quashed under the House's Democratic majority.

> ***Why should the legislature be forced to choose between two narrowly defined similar alternative experiments – essentially no choice – when there are many positive options, both statewide and nationwide, to improve the current system?***

Republican committee members Gerald Weller (R-Morris), Bernard Pedersen (R-Palatine) and Anne Zickus (R-Palos Hills) were replaced by Ann Hughes (R-McHenry), David Leitch (R-Peoria) and Arthur Tenhouse (R-Quincy). Democrats Barbara Giolitto (D-Belvidere) and Laurel Lunt Prussing (D-Champaign) were replaced by Gerald Hawkins (D-Murphysboro) and Clement Balanoff (D-Chicago). Roger McAuliffe (R-Chicago), Leitch, Tom Ryder (R-Jerseyville), Cal Skinner (R-Crystal Lake) and David McAfee (D-Summit) did not vote.

To achieve health care reform, legislators must consider a public-private mix of health care financing and preserve the advantages of the current delivery system, Dr. Goyal said. In addition, the system must include "carefully constructed cost-containment efforts," including tort reform, such as a cap on noneconomic damage awards in malpractice suits.

"To solve Illinois' health care problems, we must look at a variety of issues," Dr. Goyal said. "If we simply adopt this government-run legislation, which turns over all health care control to the government, Illinois will have not only more health care problems, but also serious economic problems. Call your legislators and express your concern." ■

Editor's note: Watch future issues of Illinois Medicine *for updates on this bill and other pending legislation that will directly affect Illinois physicians and their patients.*

Stopping smoking early stems risk

[ANN ARBOR, MICH.] Though all ex-smokers have a lower risk of developing lung cancer than do their smoking peers, kicking the habit before age 40 seems to have an advantage over quitting later in life.

"It appears that age of quitting is as important to lung cancer risk as the number of years passed without a cigarette," said Michael T. Halpern, assistant research scientist at the University of Michigan School of Public Health. "And the earlier the better."

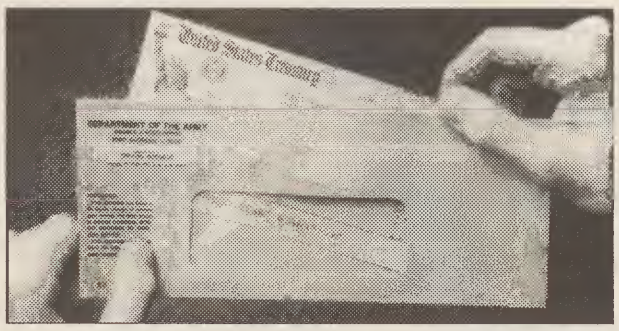
The study, published in a recent issue of the *Journal of the National Cancer Institute*, is based on health data from the American Cancer Society's Cancer Prevention Study II. Results showed that after 20 years of nonsmoking, ex-smokers who quit before age 40 had about half the risk of dying of lung cancer than smokers who quit at age 55 or older.

Yet those who quit at later ages still have only half to two-thirds the risk of dying of lung cancer than that of smokers their own age, Halpern stressed.

Study participants were aged 40 to 80. Men began smoking at about age 17 and smoked 26 cigarettes a day. Women began smoking at around 18 and puffed about 22 cigarettes each day. After quitting, lung cancer mortality rates for those who quit leveled off or rose slowly with age. ■

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A call to arms

(Continued from page 1)

notice."

Illinois lawmakers must know that their constituents are watching them, Dr. Goyal said. "Legislators represent us. Their votes on key issues should reflect what we constituents believe is best. We can't sit back and take things for granted. We have to let them know how we feel."

Dr. Goyal explained that legislators often look to the medical community as a resource on issues pertaining to health care. It's logical for busy and hardworking senators and representatives to turn to physicians to help them formulate their positions on health-related bills. But more often than not, legislators want to hear from grass-roots physicians, not professional lobbyists, he said.

"The Society's lobbyists will continue to speak to legislators, but it's the physicians in their own districts who must do most of the work," Dr. Goyal explained.

Physician input is *critical* this session particularly in light of the $250,000 cap on noneconomic damage awards legislation still pending, he said. "We saw a minor victory when the caps bill got out of the Senate Judiciary committee, but overall the fight for caps is going to be an uphill struggle given the plaintiff attorneys' stranglehold on the House," Dr. Goyal said. "We won't get caps if we don't work harder than the opposition. They're mobilized and ready to kill any attempt at reasonable tort reform. We have to let the General Assembly know the reasons caps are important and the positive effect they would have on health care costs or access." ■

Survey

(Continued from page 4)

increased because of political changes in the legislature, according to 52 percent of respondents. Forty-eight percent believe that their own party's influence has increased because of political changes. New Senate President James "Pate" Philip (R-Wood Dale) received an "expected effectiveness" rating of excellent, good or average by 97 percent of respondents, with 36 percent rating him excellent.

The survey results were tabulated by Urban Strategies Group of Chicago, which also examined the demographics of the 107 respondents. Seventy-one were incumbents, 74 were male, and half were between the ages of 41 and 50. Forty-six respondents had spent eight or more years in the legislature, while 59 had spent between one and seven years in the General Assembly. Fifty-eight were Democrats, and 47 were Republicans. Two respondents did not specify party affiliation.

"This survey serves as a barometer of the legislature's current mood for the session, which is always subject to change, and provides insight into how our Illinois lawmakers view the likelihood of adopting or rejecting several key legislative proposals," said Jack Modzelewski, executive vice president and general manager of Fleishman-Hillard's Chicago office. ■

Asset protection

(Continued from page 16)

the reach of creditors.

Under Illinois law, the proceeds of life insurance may also be protected from creditors of a beneficiary, either through the creation of a spendthrift trust or through a similar provision in the life insurance policy contract itself. The language in the contract typically permits the policyholder to direct that the proceeds be kept from any creditors of a beneficiary, or in the absence of this direction, the company can hold the proceeds of the policy under an agreement with the beneficiaries.

Annuities are given the same protected status as whole life and are an equally effective means of saving for retirement. For those who see no need for additional insurance but are interested in retirement saving beyond the amounts permitted in qualified plans and wish to shield these assets from potential creditors, an annuity may be the best answer. By moving currently exposed liquid assets into cash value life insurance or annuities, assets can be shielded with no meaningful loss of flexibility or rate of return.

The protections from creditors afforded by the statutes discussed are permanently available only to the extent that debtors file for bankruptcy under Chapter 7 of the Bankruptcy Code and fully discharge their debts. Otherwise, distributions to a debtor from the sale of a house held in tenancy by the entireties, to a participant from a qualified plan, or to a life insurance policyholder, beneficiary or annuitant could all be attached by a creditor as they are made. For those who face an adverse judgment or similar substantial debt, there is every reason to seek the protection both of federal bankruptcy laws and these Illinois statutes. ■

Did you forget to pay your dues?

If you received a letter from ISMS saying you will be removed from the membership rolls because you haven't paid your 1993 dues, don't panic. But act now.

If you obtain your malpractice insurance through the Exchange, failure to pay membership dues to your county society, ISMS and the AMA jeopardizes your liability coverage. Malpractice coverage through the Exchange is a membership benefit; only Society members in good standing can be policyholders.

The deadline for paying membership dues and retaining your Exchange malpractice insurance is July 1. If you fail to pay your dues by that date, your Exchange policy will lapse, and technically, you will be practicing medicine without liability coverage.

Members who choose not to renew are encouraged to complete the survey accompanying the nonrenewal letter regarding their reasons for discontinuing membership.

If you received a nonrenewal letter but have already paid your dues, contact the ISMS membership department at (312) 782-1654 or (800) 782-ISMS. To ensure uninterrupted Exchange coverage, have your county medical society contact ISMS to verify that your dues have been paid. ■

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol*. 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)
CONTRAINDICATIONS
Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be edministered to women of childbeering ege only when such patients are highly unlikely to conceive end have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renel dysfunction secondery to myoglobinuria hes been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Prevestatin therepy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an ecute or serious condition predisposing to the development of renal failure secondery to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; traume; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibretes alone may occasionelly be associeted with myopathy. The combined use of pravastatin end fibrates should generally be avoided.**

PRECAUTIONS
General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interections: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnency: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS
Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Leboretory Test Abnormelities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therepy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interections.**)

OVERDOSAGE
There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Bristol-Myers Squibb Company

THE PRAVACHOL® DIRECTION IN LIPID MANAGEMENT

Effective lipid management doesn't have to be tough

- Improves key lipids — significant reduction in LDL-C[1]
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- Usual dose: 20 mg once daily at bedtime, with or without food

PRAVACHOL®

pravastatin sodium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

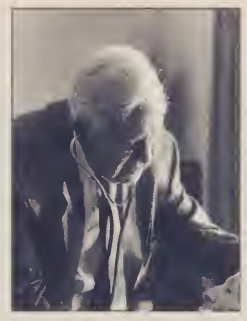
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INCREASING HIV INCIDENCE UNDERLINES NEED TO ASSESS PATIENTS (PAGE 9)

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HOW TO CONTACT YOUR STATE LEGISLATORS
PAGE 15

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Special insert: "Putting Patients First"

Exchange announces '93 changes

SERVICE INITIATIVE: The Exchange is lowering premiums for policyholders with good loss records. By Tamara Strom

[CHICAGO] For the second year, the Exchange is providing discounted premium levels to policyholders with loss-free records. The initial 3-percent discount will be given to all Exchange policyholders who have experienced no payouts during the past three years. Physicians with no paid losses over the past 10 years are eligible for discounts up to 10 percent.

"The premium discounts reward physician policyholders who have excellent loss records," said Harold L. Jensen, MD, chairman of the Exchange Board of Governors.

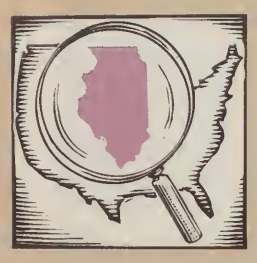
Dr. Jensen stressed that the discounts do not penalize physicians who are sued. "Most physicians have been sued at one time or another," he said. "That's why even if they've been sued in the past, physicians who haven't had payouts in the past several years will pay lower premiums."

Favorable loss experience prompted the Exchange to lower premiums for dermatologists

(Continued on page 11)

INSIDE

State organ registry increases donor pool
PAGE 5



IDPA sets wheels in motion for drug use review program
PAGE 4

DEPARTMENTS

News Briefs.....2
Commentary.....6
Letters.....7
Members in the News.....8
ISMIE Update.....9
Classifieds.....12



Photo courtesy American Medical Association

ISMS President-elect Arthur R. Traugott, MD (right), met with U.S. Rep. Thomas W. Ewing (R-Bloomington) to provide physician input about health care reform during the AMA's March health care summit in Washington.

Lawmakers advance tort reform countermoves

LEGISLATION ROUNDUP: With prejudgment interest, birthing centers and mandatory assignment bills proceeding, physicians hope to halt potentially harmful legislation. By Anna Brown

[SPRINGFIELD] Medicine is working in the General Assembly to advance legislation to protect physicians and their patients. Prejudgment interest and "respondent in discovery" bills have already advanced to the floor in the Illinois House of Representatives.

Both H.B. 2111, a prejudgment interest bill sponsored by Rep. Louis Lang (D-Skokie), and H.B. 1369, a respondent-in-discovery bill sponsored by Rep. John Dunn (D-Decatur), emerged from committee and



await floor debate. H.B. 2111 calls for liability judgments to draw 9-percent interest per year, compounded annually, from the date the complaint is filed until the judgment is satisfied. The interest rate would drop to 6 percent for judgments assessed against government entities, according to the bill. Organized medicine helped defeat nearly identical measures during past legislative sessions.

ISMS opposes H.B. 2111 because it would almost double awards and increase costs to physicians and professional liability insurers in Illinois, as well as create further delays in an already backlogged court system. The bill would affect all

(Continued on page 14)

Public health bills take some heat

GENERAL ASSEMBLY: Legislators address gun control, motorcycle helmets and tanning parlor regulation. By Anna Brown

[SPRINGFIELD] Public health legislation was one of several topics on legislators' agendas when they returned from Easter break to debate bills on the House and Senate floors. Physicians have already scored a few preliminary successes in Springfield this session, with some medicine-supported bills emerging from committee. However, the state's economic condition has helped quash several new programs. Some issues of interest to ISMS members, such as gun control and mandatory motorcycle helmet measures, seem to be headed for a fairly bleak legislative season.

Gun control remains a hot issue in the Capitol, with 50 to 60 new bills introduced this year. But very few of them advanced out of committee. Introduced by Rep. Louis Lang (D-Skokie), H.B. 91 would have prohibited storing loaded firearms where they would be accessible to minors. S.B. 40, introduced by Sen. Grace Mary Stern (D-Highland Park), would have made it a Class A misdemeanor if a child under 14 found an adult's gun and used it to kill someone or cause "great bodily injury." Both bills were supported by ISMS. House of Delegates policy supports owner-liability laws, state gun registration, buy-back programs, mandatory locked storage in homes with minors,

(Continued on page 15)

PUTTING PATIENTS FIRST

By Jere E. Freidheim, MD
ISMS board chairman

This issue of *Illinois Medicine* contains a special section, "Illinois Physicians – Putting Patients First," highlighting Illinois physicians' concerns for our patients. Patients are our No. 1 priority, and they should know that. So "Putting Patients First" should be placed where your patients can see it. It's our story, in words and pictures, about how Illinois physicians fight for patients.

Physicians have been unfairly blamed as the culprits behind health care cost increases. Chicago writer Mike Royko, in his column (reprinted on page 7 in this issue), provided some respite for us when he named societal problems such as alcohol and substance abuse, violence and poor health habits as the bad guys. And, while we know that the way to speak out for ourselves is not by blaming someone else, we salute Royko's talent and courage when he disagrees with the trendy theory of the moment.

(Continued on page 14)

ISMS continues health care reform input

DEBATES: Discussions intensify over caps and a single-payer health care system. By Rachel Brown

[CHICAGO] ISMS President Arvind K. Goyal, MD, participated in recent debates focusing on two important health care reform issues: caps on noneconomic damages in malpractice awards and the establishment of a single-payer health care system.

In an April 8 medical malpractice debate sponsored by DePaul University Law School, Dr. Goyal argued in favor of capping noneconomic portions of malpractice awards and questioned whether health care reform without tort reform will work.

During the two-hour debate, which also featured the president of the Illinois Defense Counsel and two plaintiff attorneys, heated discussion addressed equitable compensation for victims of medical malpractice, the costs of defensive medicine and self-referral.

Dr. Goyal told audience members that a $250,000 cap on noneconomic damages would reduce the number of "windfall" malpractice awards, restore fairness in the country's tort system and increase access to health care.

"We have a serious problem in health care, and something has to be done," said Dr. Goyal. "Although capping noneconomic awards may not be a total solution, it is a step in the right direction."

The plaintiff attorneys and several audience members questioned the fairness in limiting awards to those patients seriously injured through medical negligence. Dr. Goyal pointed out, however, that reform should concentrate on inefficiencies in the current system, which allow some victims to receive little or no compensation, while others collect "huge, lottery-type" awards.

ON MARCH 31, Dr. Goyal was one of four panelists participating in a universal health care debate at the Oak Park Public Library. The debate, held before community residents favoring single-payer health reform, was sponsored by the self-proclaimed consumer advocacy group Campaign for Better Health Care.

An HMO-industry representative joined Dr. Goyal on the panel to discuss the drawbacks a single-payer, government-run health delivery system would have on access and quality of care. Other panelists included an ethics professor and an Illinois Nurses Association representative, both of whom endorsed a single-payer health system.

Dr. Goyal told attendees that the U.S. health delivery system provides the best health care in the world to most of this country's citizens. "While the current system is not without fault, it would be a horrible mistake to scrap it for a system that would ration care and stifle medical technology."

Proponents of a single-payer system who participated in the debate claimed that a Canadian-style, government-controlled system would provide universal access to the 37 million Americans currently uninsured and the millions more who are underinsured. But Dr. Goyal cautioned the audience that such government-controlled health reform plans promise more than they can deliver.

"A single-payer system promises universal access to care," he said. "What it delivers is universal rationing of care. Unless taxes are continually increased to fund the program, the enormous costs associated with providing such comprehensive care will eventually reduce the services that can be provided." ■

Hospital coalition calls for continued assessment

[CHICAGO] Endorsing Gov. Jim Edgar's support for temporarily continuing the Medicaid health facilities assessment program, a coalition of 22 hospitals is urging the General Assembly to extend the program past its June 30 expiration date. Without legislative action to keep the plan in place, Illinois stands to lose $1.5 billion in Medicaid funding. Under federal law, Illinois can obtain federal funds matching the dollars it spends reimbursing medical facilities that care for the poor.

"We applaud Gov. Edgar's continued support for Medicaid funding in Illinois, and we urge the General Assembly to recognize that the current Medicaid assessment is the only practical short-term solution to generating these necessary Medicaid dollars," said Benn Greenspan, spokesperson for Hospitals United for Health Care Access.

Lacking alternatives, the governor's Health Care Reform Task Force recommended continuing the assessment program for two years and urged the state to develop long-range funding options. Hospitals United members believe the assessment program must continue until a viable funding alternative is identified, Greenspan said. Although Edgar included an assessment program in his 1994 budget proposal, he said he will work with the General Assembly to hone program details when the federal government announces relaxations of the rules governing the matching fund plans.

The Hospitals United for Health Care Access coalition includes "disproportionate share hospitals" such as Cook County Hospital, Mercy Hospital and Medical Center, Centreville Township Hospital and Wyler Children's Hospital, as well as other hospitals that treat Illinois Medicaid and charity cases. To keep afloat financially, these hospitals depend on the higher reimbursement rates guaranteed by the assessment plan. According to IDPA, the average Medicaid patient load for Illinois hospitals is 15.5 percent, but many of the disproportionate-share hospitals average 44 percent. ■

Illinois physician indicted for fraud

[EAST ST. LOUIS] An East St. Louis federal grand jury indicted Thomas Bruce Vest, MD, a radiologist from Godfrey, on 40 counts of mail fraud. The March 18 indictment announcement in East St. Louis is part of the federal government's ongoing investigation to uncover fraud in health care.

The indictment alleges that Dr. Vest built a $13 million "medical diagnostic clinic" called "Doctors Clinic" in Alton to provide radiology testing services to area residents. The government investigators said that Dr. Vest paid for the facility by providing "testing services that patients did not need and sent the bills to Medicare or to the private insurance companies. Any billed amounts that Medicare or the insurance companies refused to pay were billed directly to the patients."

The indictment contends that Dr. Vest recorded "false and fraudulent" symptoms in patients' medical records to justify tests he ordered and for which he subsequently submitted claims.

Dr. Vest called the indictment a "conspiracy," and said the government had "no cause whatsoever" for investigating him. All 40 counts are "bogus," Dr. Vest said, explaining that his records show the patients cited in the indictment were "happy with the results" of the care he provided. Dr. Vest said he plans to represent himself.

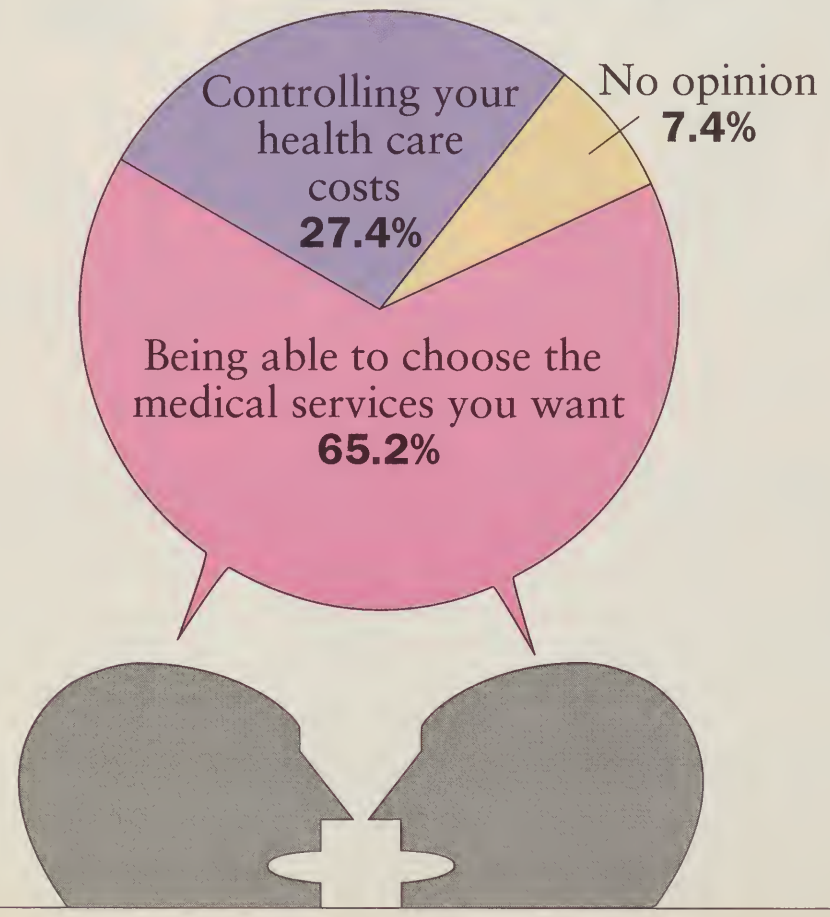
Each of the counts against Dr. Vest carries maximum penalties of a five-year jail term, a $250,000 fine or both, and two to three years of supervised release. The charges against Dr. Vest were filed after a joint investigation by the FBI, the U.S. Department of Health and Human Services' Office of Inspector General and other agencies. The Illinois State Police also provided assistance.

The FBI and OIG are currently investigating other alleged instances of health care fraud in Illinois, some involving physicians, said Michael Dyer, regional inspector general. "Fraud investigation is an ongoing process. We have cases across the board – DME suppliers, hospitals, home health organizations – they run the whole gamut of health care." ■

PHYSICIAN FACTS

Between Jan. 14 and Jan. 28, 1993, Novalis Corp. surveyed 1,000 randomly selected adults living in the United States regarding health care reform. The survey included the following question:

Which do you think is more important, controlling your costs for health care or being able to choose the medical services you want?



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Depression awareness campaign launched

[ALEXANDRIA, VA.] To increase public awareness that clinical depression is a treatable medical illness, the National Mental Health Association launched a national education campaign in 31 cities across the country, including Chicago.

The three-week campaign, cosponsored by the American Psychiatric Association, began in Chicago April 5 with television and print ads explaining the symptoms of clinical depression. The ads also described the effectiveness of treatments such as medication and therapy.

"If someone encounters five or more symptoms of clinical depression – such as changes in eating and sleeping patterns, loss of energy or feelings of helplessness – for two weeks or longer, we want them to see a doctor," said John Horner, NMHA president and CEO.

Clinical depression strikes more than 12 million U.S. adults each year, costing the country $27 billion in health care bills and lost workdays and productivity, according to NMHA. Despite the availability of effective therapies, only about one-third of depressed adults seek treatment. Fifteen percent of severely depressed adults who fail to obtain treatment ultimately commit suicide, the association added.

A similar campaign conducted in Jacksonville, Fla., netted positive results, according to the association. A sample of Jacksonville primary care physicians polled after the project said they were more aware of the symptoms and more willing to discuss the illness with their patients. ■

Government to develop cancer pain guidelines

[WASHINGTON] To help relieve the unnecessary suffering and impairment of family life and career faced by many cancer patients, the Agency for Health Care Policy and Research has formed a panel to develop clinical practice guidelines for managing cancer pain.

AHCPR, a component of the U.S. Public Health Service within the Department of Health and Human Services, released guidelines on managing acute pain in March 1992.

In developing the pain management guidelines, the 14-member panel of physicians, nurses, pharmacists, psychiatrists, psychologists and a consumer will review extensive scientific literature.

AHCPR Administrator J. Jarret Clinton, MD, noted that an estimated 1 million Americans are diagnosed with cancer every year, and one in five deaths is attributable to cancer. Nearly half of all cancer patients report moderate to severe pain at the time of diagnosis, Dr. Clinton added, and 65 percent to 90 percent report severe pain when cancer reaches an advanced stage.

Dr. Clinton said cancer pain can cause unnecessary and sometimes intense suffering, leading to diminished activity, loss of sleep and other emotional disturbances that can hasten a patient's decline.

"Every cancer patient should have the expectation that pain control will be an integral aspect of care throughout the course of the disease," Dr. Clinton said. ■

Photo courtesy IRHA



FOR THE SECOND TIME this year, George Mitchell, MD, of Marshall, has been recognized for his contributions to rural health care. Nola Gramm, president of the Illinois Rural Health Association, presented Dr. Mitchell with the "Rural Health Practitioner of the Year" award at the IRHA annual awards luncheon March 24 in Effingham.

An advocate for rural health issues, Dr. Mitchell was instrumental in forming the ISMS Rural Health Subcommittee. He established the Cork Medical Center in Marshall, which is also used to educate physicians about rural practice.

Blue Cross® Blue Shield® REPORT FOR *Illinois Physicians*

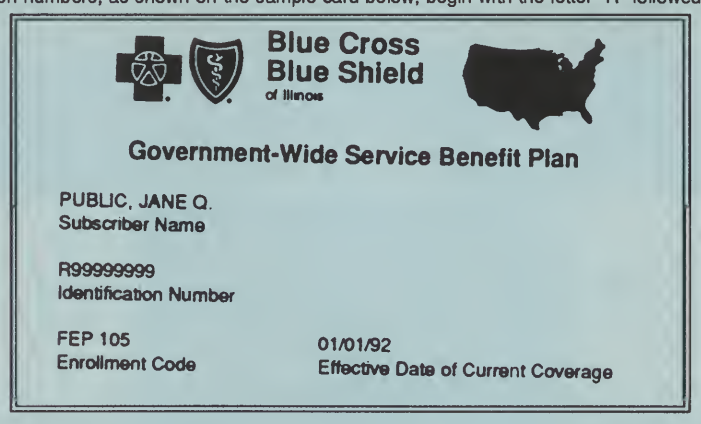
* 1993 FEDERAL EMPLOYEE PROGRAM (FEP) BENEFITS CHANGES *

CORRECTION

This article corrects information found in the January 15, 1993 *Blue Cross Blue Shield Report for Illinois Physicians.* The 1993 benefit package for the Federal Employees Program (FEP) introduces a nation-wide preferred provider (PPO) network, reflecting a mainstream managed care philosophy emphasizing a cost-effective provider network design that encourages the use of preferred providers. Members of the FEP will receive a higher level of reimbursement when they receive care from preferred providers.

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PPO/Preferred Physician	• Pays 95% of Maximum Schedule of Allowances	• $200 deductible/Pays 95% of Maximum Schedule of Allowances
Participating Physician	• $150 deductible/Pays 80% of Maximum Schedule Allowances	• $200 deductible/Pays 75% of Schedule of Maximum Allowances
OFFICE VISITS	Including home and office visits. This includes office visits in conjunction with the covered routine screening tests when the provider is a preferred physician.	
PPO/Preferred Physician	• $10 copayment	• $10 copayment
ROUTINE (SCREENING) SERVICES	In addition to current benefits for routine mammograms and pap smears, two new preventive screening services have been added for 1993. These tests are the Prostate Specific Antigen (PSA) test or prostate cancer screening and the fecal occult blood test for colorectal cancer screening.	
PPO/Preferred Physician	• $10 copayment	• $10 copayment

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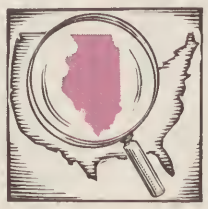
Medical Services Advisory
Hours: 7:00 a.m. - 7:30 p.m.
Telephone number: (800) 227-6591

(4/23/93)

IDPA sets wheels in motion for drug review program

PATIENT EDUCATION: Public Aid is working with Illinois physicians and pharmacists to meet federal DUR requirements. By Gina Kimmey

[SPRINGFIELD] Under federal mandate to implement a drug review program by Jan. 1, 1993, or lose federal Medicaid funding, the Illinois Department of Public Aid started a new Drug Utilization Review program. The DUR program's goal is improving quality of care and cost containment by examining



the therapeutic appropriateness of drugs used by Medicaid patients.

The theory behind drug utilization review is "education through discussion," said Starlin Graetting, the program's coordinator. By reviewing patient profiles and identifying problem areas, the program will encourage positive changes in drug usage patterns, because prescribing choices will be based on more complete patient and medical information, Graetting said.

The program's first order of business was establishing a multidisciplinary governing board composed of 13 representatives from the Illinois physician and pharmacist communities, she said. As the program's governing body, the board is responsible for developing a strategic plan and setting the program's direction.

At its first meeting, the board settled on a procedural process and is now developing bylaws. The board will also organize and operate "regional review DUR workshops," Graetting said. These groups could include two to four physicians and pharmacists, who will handle confidential drug profile reviews of Medicaid recipients in their region, and will report monthly to the full board.

The board will also review current patterns of drug use and develop educational materials detailing their findings for physicians and pharmacists.

"The purpose of the program is, in one word, education," said DUR Board Chairman Eugene P. Johnson, MD, of Casey, a former ISMS president and trustee. "Hopefully, it will improve the relationship between pharmacists and physicians, and in turn benefit the patient."

> *Our function is education. We hope the end result will be improved quality of care.*

Other ISMS members serving on the board are Vice Chairman Vincent A. Costanzo Jr., MD, of Chicago; Alex J. Spadoni, MD, Hinsdale; Marshall L. Blankenship, MD, Chicago; Armand Littman, MD, Evanston; Pedro A. Poma, MD, Oak Brook; and Lawrence P. Jennings, MD, Mount Carmel.

Another program objective is boosting communication between physicians and pharmacists, Graetting said. "Existing good relationships between physicians and pharmacists won't change, but those pharmacists who see themselves as simply providers of a product" will be required to get more involved in counseling patients, Graetting said.

The Omnibus Budget Reconciliation Act of 1990 requires pharmacists to share their knowledge about drugs with patients by discussing proper medication preparation, administration and dosing; potential side effects; and actions to take in the event of drug interactions, she noted. Pharmacists will augment physicians' roles, not replace them, she said. "The first and foremost problem we [hope] to address is underuse or overuse of drugs, particularly by the elderly population."

As part of the program, pharmacists will create a drug profile of each Medicaid patient, including name, address, phone number, age, gender and medication history. Patients may refuse to provide this information to their pharmacist, IDPA said. The medication history could include information related to allergies, drug reactions, current medications and disease status. The profiles are intended to help identify potential drug therapy problems caused by therapeutic duplication, drug interactions, drug-allergy interactions, and clinical abuse or misuse.

Details about the program will be sent soon to Medicaid-participating pharmacies, physicians and hospital outpatient departments, according to IDPA. "This program is not punitive," Dr. Johnson said. "Our function is education. We hope the end result will be improved quality of care. This is our goal." ■

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State organ registry increases donor pool

ORGAN AVAILABILITY: Illinoisans can become potential donors by signing their driver's licenses and registering with the state. By Anna Brown

[SPRINGFIELD] The office of Secretary of State George Ryan is celebrating the early success of Illinois' state organ registry during National Organ and Tissue Donor Awareness Week, April 18-24. The registry, which began in September 1992, may have already shown that Illinoisans consider organ donation more than citizens of other states do.

In Illinois, 23 percent of drivers statewide have indicated their willingness to become organ donors by signing the reverse side of their driver's license or joining the donor registry, according to Ryan's spokesperson John Torre. The national average is only about 10 percent, Torre said. In a national Gallup survey released in March, 69 percent of Americans said they would be willing to donate organs when they die, but have never told family members about their decisions.

"This has always been an obstacle to increasing organ donations," Torre said. Family members' knowledge of their loved ones' wishes is key to recovering organs, he explained, since relatives must agree to the organ donation even if donors have signed their driver's licenses or are members of the organ registry.

> *Family members' knowledge of their loved ones' wishes is key to recovering organs.*

Since 1984, Illinoisans could indicate their willingness to become organ donors by signing their driver's licenses. Individuals may choose to donate a specific organ or their entire bodies, and two people must witness the signature.

Now when Illinoisans apply for or renew their licenses, Secretary of State's office employees ask applicants if they want to join the organ registry, Torre explained. Positive responses are recorded in the office's data base. Two organ procurement groups – the Regional Organ Bank of Illinois and Mid-America Transplant Association – access the data base through a confidential toll-free phone number staffed 24 hours a day.

The procurement groups call the data base when they need to approach a family about releasing a relative's organs for donation, Torre said. If the individual was registered with the state, the groups can inform the donor's family that the person had decided to become a donor.

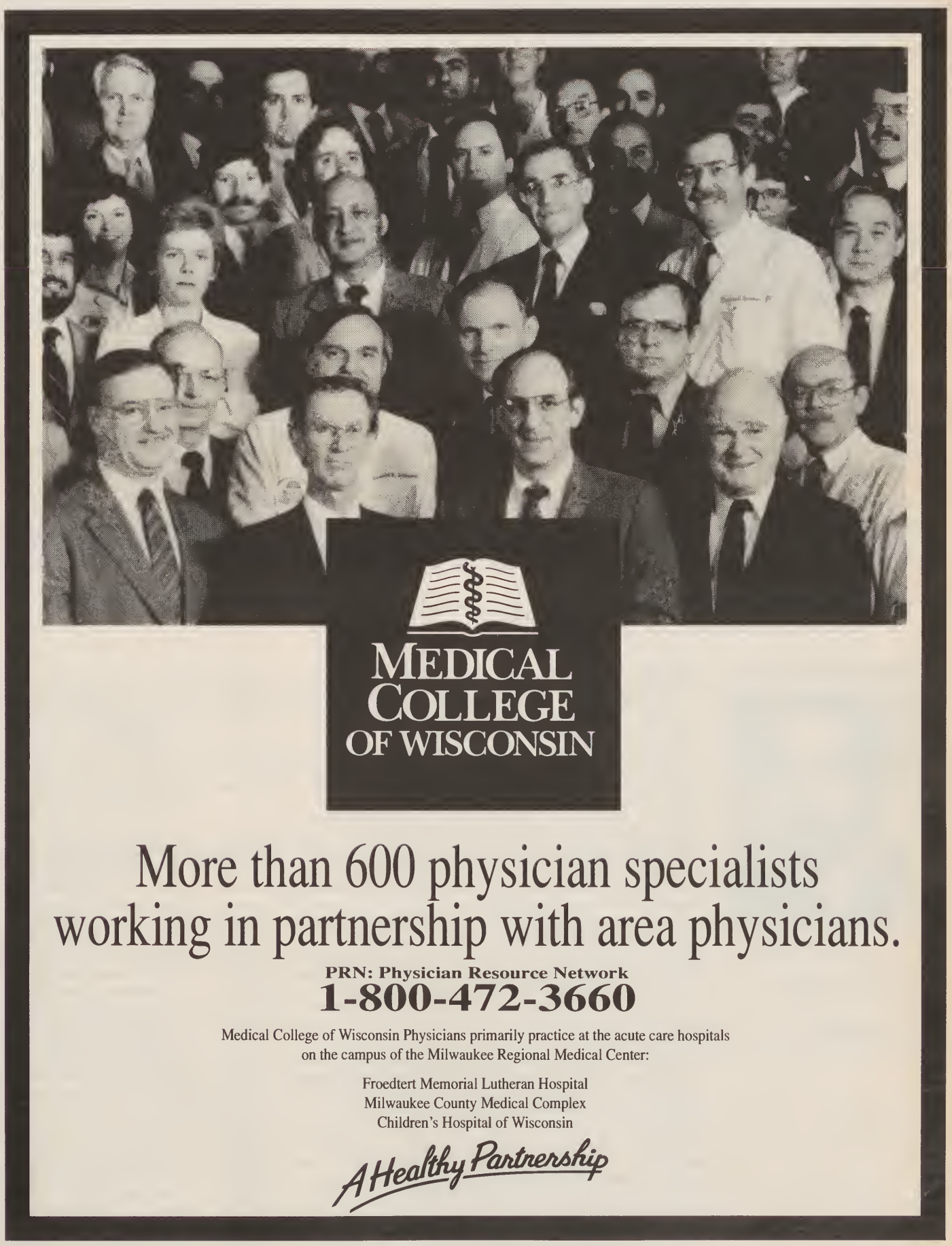
Torre stressed that people who join the registry should also sign the back of their driver's license, even through most organ donors are trauma victims who may not have their licenses with them when their organs are available for harvesting.

BECAUSE DRIVER'S LICENSES are renewed every four years, by the end of 1996, all Illinois drivers will be asked to participate in the registry, Torre said. To date, more than 156,000 Illinois residents have joined the registry. Illinois is the fourth state to create a donor registry; Florida, Maryland and Ohio also have them.

The Regional Organ Bank of Illinois projects that 600,000 Illinois drivers will be registered as potential organ donors after the program's first year. ISMS policy supports legislation to encourage retrieval of organs for transplantation.

"We are hopeful that the registry will have a long-term impact, significantly increasing the pool of applicants," Torre said. "However, in spite of our efforts, the waiting list for organs increased last year in Illinois." In fact, the waiting list for people in need of organs increased by 28 percent in 1992, Torre said, with 1,062 people on the list in January 1992 and 1,359 people on the list at year's end.

Statistics such as county breakdowns are also available through the data base, Torre said. To date, McHenry County has the highest sign-up rate, with 39 percent of residents joining the donor registry. The Secretary of State's office plans to use the statistics to target public awareness campaigns at counties with lower registration rates. The campaigns will include health fairs and printed materials for county health departments in areas with limited participation. The office will also sponsor poster contests and other events aimed at helping children become more comfortable with the idea of organ donation. ■



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EDITORIAL

Fact and fiction

The Illinois Trial Lawyers Association has pulled out another deceptive device from its bag of tricks. The group recently mailed its members a flier – prepared by the Coalition for Consumer Rights, a self-proclaimed consumer advocacy group – suggesting that they buy and distribute extra copies. The flier is riddled with unreferenced statistics, distortions and false accusations aimed at doctors.

Among the more inflammatory remarks are the following: "Illinois' doctors' lobby knows that health care costs are high. They blame patients and want to cap the amount that injured patients can recover from bad doctors."

Most of the time, claims against physicians simply do not correspond with negligent adverse events. ISMIE reports that 80 percent of all medical malpractice claims and suits are unfounded and are closed with no payment. That statistic was corroborated by a 1990 Harvard University study reported by the AMA in its Medical Liability Project: "Eighty percent of the claims for medical malpractice lacked any evidence of negligence in the hospital chart." And of the 3 percent of ISMIE claims that actually go to trial, 74 percent are won by doctors.

An interesting statistic from the Rand Corp., also reported by the AMA, is that only 43 percent of every dollar spent on medical liability litigation reaches injured patients as compensation. The rest is spent on attorneys' fees, litigation expenses and insurance administration costs.

The flier's diatribe continues with, "Doctors resist policing themselves. Studies show the state isn't much better, bringing actions against only 1 percent of doctors, mostly for technicalities." The implication is that patients would somehow be better served if more doctors required discipline. The fact is that since state licensure and discipline processes became more stringent through revision of the Medical Practice Act in 1987, any problem doctors are being weeded out early in the process, meaning there is less need for discipline down the road.

Unfortunately, the flier fails to mention how the professional liability climate harms patients – the indigent and residents of medically underserved areas – by reducing access to physicians. Nor does it cite that 77 percent of U.S. adults think malpractice suits and awards are an important reason for rising health care costs, according to a June 1991 Gallup Poll.

And it especially doesn't say that only claims with high award potential are considered worth pursuing by the plaintiff bar or that attorneys receive a substantial portion of damages awarded in product liability and medical malpractice cases. So who's really limiting the amounts injured patients can recover?

PRESIDENT'S LETTER

Well or not so, he did his best

By Arvind K. Goyal, MD



And now I can be my usual self again!

"Now, how many of you would like to go to heaven?" asked the Sunday school teacher. All the eager 5-year-olds except Billy raised their hands. "I am sorry," he said, "I can't – my mother told me to come right home after Sunday school".

As I sit down for this one final time to write my last president's report for you, I feel like little Billy. They tell me it'll be over by the time you read this column in two weeks. The bell will ring. The period will be over. And then I should come straight home!

Since my last report to you in January, I have worn out two pairs of those bone-white Rockports, and lived through some snowstorms and icy roads, and worse, reports from the Campaign For Better Health Care, the Coalition For Access To Care, Public Citizen and the like. Another group, calling itself a coalition for consumer rights, which some say the Illinois Trial Lawyers Association founded and still funds, came up with a survey in 45 rural counties of its choosing. Their inference: Rural counties have high malpractice insurance premiums compared to their lesser lawsuit experience. You can come up with any desired conclusion, that is, if you choose your subject and design carefully – a message I remember from my statistics 300 class. Well, for reasons of high malpractice premiums and plain fear of malpractice, some of those border counties had no physicians, so they couldn't be sued. If patients there had an irresistible desire to sue, they would have to do it across the state border, where they frequently go for their medical care.

I lost more hair while testifying in Springfield on your behalf on caps for noneconomic awards one day last month at the House Judiciary Committee hearing, where they killed the bill. After a similar hearing the very next day, the Senate Judiciary Committee voted to move the bill to the Senate floor, thus underscoring the need to talk "caps" with state senators! I felt like an expert on the subject by the time of a debate on the same topic at DePaul Law School a week later. I'd rather hear the law students again than some of those panelists!

The students' perspective really hit home in Rockford and in Lincoln where junior high students and their teachers allowed me to explain why it was important to stay clean, why they must say "no" to drugs, alcohol and cigarettes. Some of their questions, of course, didn't have answers. I had fun writing back to the 20-some sixth-grade students at Marsh School in Rockford who followed up with their first business letter to me. The winner, I thought, was the student who wrote, "Now I know how to talk to my father and tell him about second-hand smoking. ..." And a close second was Melissa, who stated, "I would never want to take drugs because I would like to be a pro NHL goalie. ..." I had no trouble reading any of their handwriting, proof our future is in good hands!

Participation at the annual Leadership Conference of the AMA, the annual AMA-IMG Forum and neighboring state medical society meetings has continued to add to the learning that comes with the job. Visits to county medical societies – including the first such meeting in Effingham – as well as meetings with some of the hospital medical staffs and then the mother of them all, the Illinois Hospital Medical Staff Section's annual meeting, and with several specialty and ethnic medical societies, including those representing Indian and Filipino physicians, were inspiring as usual.

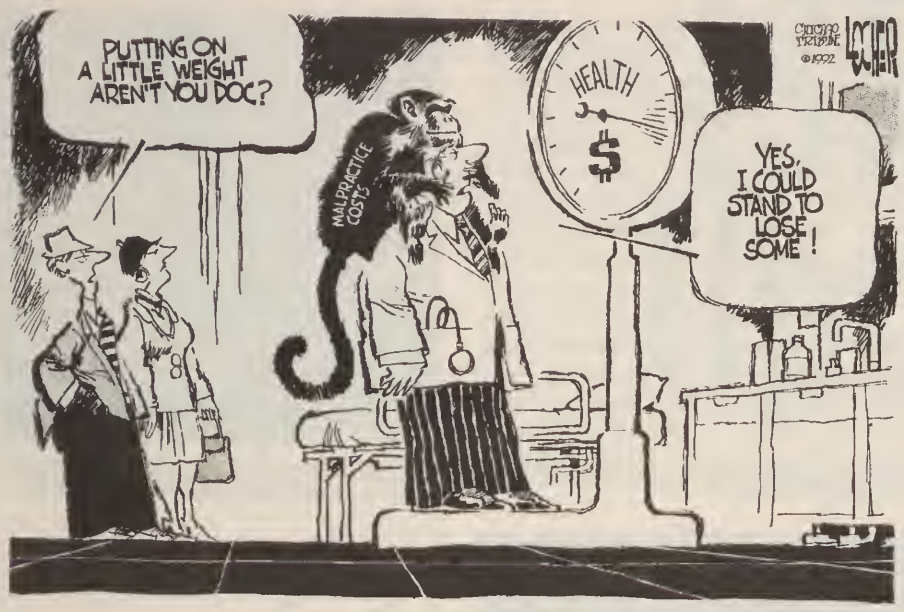
Key messages have been delivered on your behalf to anybody who'll hear: the White House task force chaired by Mrs. Clinton, Illinois attorney general's task force hearing on domestic violence, Rep. Bobby Rush's town hall meeting on health care at Chicago State University, National Health Insurance Underwriters meeting in Lincolnshire, citizens of Oak Park at their library, and several other professional and civic groups all over the state. Radio, TV and print media have been used on-call and PRN.

Your society's principles on health care reform took center stage before 800-plus physicians at the Midwest Clinical Conference of my own county society – the Chicago Medical Society. Also humbling was a special presentation at my own Irving Park Suburban Branch meeting on Doctor's Day.

Exploration of issues related to economic credentialing by hospitals took up any free time I may have otherwise had. Meetings with representatives of ADAPT and discussion with the president of the Illinois Nurses Association during my last president's call-in hour, added more than just dimensions to my representation on your behalf. And seeing patients at the free clinic in Waukegan allowed me to work, not just talk, during my tour of Lake County.

The time has now come, my fellows, my friends, for me to pen a final thank-you for all your graces, encouragement, education and prayers. A tombstone in a town cemetery read, "I expected this, but not so soon." I felt this way when you elected me president for a whole year. And I have increasingly sensed a similar feeling during the countdown to finish my term, my implied "contract" to serve you and this society better than my ability. And now I can be my usual self again! ■

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LETTERS

Physician participation in executions unethical

Why are you shilling for the Illinois Department of Corrections in the "Medical Legal Guidelines" in the March 12 *Illinois Medicine*? The Illinois attorney general's letter of July 1, 1992, which was quoted (out of context) was one of disagreement with the medical profession's strong stand that doctors who help executioners by monitoring the killing process are in serious violation of the ethical standards of their profession. This letter was written for the Department of Corrections in support of its continuing effort to "medicalize" the execution process. Your guidelines fail to advise physicians that their role in this process of determining, pronouncing or declaring death for the executioner violates the Medical Practice Act and AMA and ISMS ethical standards, and would subject them to discipline. And you fail to point out that although some acts may be legal, they also may be seriously unprofessional, dishonorable and unethical, and that the profession's standard applies in this situation.

You offer a dissociated rationale devoid of ethical meaning or context, a rationale designed to help the execution team keep psychological distance from the killing process. Then you attempt to represent it as "medical legal" advice to physicians. Give us a break!

We don't need the attorney general telling us that only doctors can determine, by cardiorespiratory criteria, when death has occurred, when paramedics, nurses, detectives, coroners, funeral directors and a bunch of other people with good medical knowledge already know better. We would not be credible if we asserted the same thing.

These people and doctors know that brain death in hospitals is an altogether different matter. The medical profession itself set the standards for definition of brain death to be used in end-of-life and organ-donation situations, governed respectively by the Health Care Surrogate Act and the Uniform Anatomical Gift Act. Physicians certainly have a major role in these situations. However, to lump them with the execution law as if they were related is a disservice, if not the height of egregious incompetence.

– William P. Gibbons, MD
Medical Director
Pathology and Laboratory Medicine
Copley Memorial Hospital
Aurora

Editor's note: Dr. Gibbons' letter correctly points out that the medical legal guideline on death fails to explain that physician participation in legal executions violates Illinois' Medical Practice Act. Specifically, state law says that engaging in unethical behavior violates the Medical Practice Act. Similarly, AMA and ISMS House of Delegates policy state that physician participation in executions is unethical.

The "Medical Legal Guidelines" were developed by the ISMS Medical Legal Council, to standardize information about state law and legal counsel opinions and communicate that information to Illinois physicians. Dr. Gibbons' concerns have been forwarded to the council, which will reconsider this particular guideline and its relationship to the Medical Practice Act's ethical implications. ISMS continues its efforts to carry out its policy deeming physician participation in executions unethical.

Mammography frequency questioned

The March 12 "Case in Point" on mammography stated, "Physicians should also use the most aggressive guidelines when counseling patients on follow-up mammograms, according to *risk management* experts." It then states the recommendations of the American College of Radiology and the American Cancer Society. There are many *medical* experts who do not believe that mammography is of proven cost-effectiveness for women under age 50. Also, the optimal frequency of mammography (every one or two years) remains unknown.

– John F. Stoll, MD
Adult Medicine Division
Carle Clinic Association
Urbana

GUEST EDITORIAL

Doctors' pay poll reflects sick society

By Mike Royko

On a stupidity scale, a recent poll about doctors' earnings is right up there. It almost scored a perfect brain-dead 10.

It was commissioned by some whiny consumers group called Families USA.

The poll tells us that the majority of Americans believe that doctors make too much money.

The pollsters also asked what a fair income would be for physicians. Those polled said, oh, about $80,000 a year would be OK.

How generous. How sporting. How stupid.

Why is this poll stupid? Because it is based on resentment and envy, two emotions that ran hot during the political campaign and are still simmering.

You could conduct the same kind of poll about any group that earns $100,000-plus and get the same results. Since the majority of Americans don't make those bucks, they assume that those who do are stealing it from them.

Maybe the Berlin Wall came down, but don't kid yourself, Karl Marx lives.

It's also stupid because it didn't ask key questions, such as: Do you know how much education and training it takes to become a physician?

If those polled said no, they didn't know, then they should have been disqualified. If they gave the wrong answers, they should have been dropped. What good are their views on how much a doctor should earn if they don't know what it takes to become a doctor?

Or maybe a question should have been phrased this way: "How much should a person earn if he or she must [a] get excellent grades and a fine educational foundation in high school in order to [b] be accepted by a good college and spend four years taking courses heavy in math, physics, chemistry and other lab work and maintain a 3.5 average or better; and [c] spend four more years of grinding study in medical school, with the third and fourth years in clinical training, working 80 to 100 hours a week; and [d] spend another year as a low-pay, hard-work intern; and [e] put in another three to 10 years of postgraduate training, depending on your specialty; and [f] maybe wind up $100,000 in debt after medical school; and [g] then work an average of 60 hours a week, with many family doctors putting in 70 hours or more until they retire or fall over?"

As you have probably guessed by now, I have considerably more respect for doctors than does the law firm of Clinton and Clinton, and all the lawyers and insurance executives they have called together to remake America's health care.

Based on what doctors contribute to society, they are far more useful than the power-happy, ego-tripping, program-spewing, social tinkerers who will probably give us a medical plan that is to health what Clinton's first budget is to frugality.

But propaganda works. And, as the stupid poll indicates, many Americans wrongly believe that profiteering doctors are the major cause of high medical costs.

Of course doctors are well compensated. They should be. Americans now live longer than ever. But who is responsible for our longevity – lawyers, Congress or the guy flipping burgers in a McDonald's?

And the doctors prolong our lives despite our having become a nation of self-indulgent, lard-butted, TV-gaping couch cabbages.

Ah, that is not something you heard President Clinton or Super Spouse talk about during the campaign or since. But instead of trying to turn the medical profession into a villain, they might have been more honest if they had said:

"Let us talk about medical care and one of the biggest problems we have. That problem is you, my fellow American. Yes, you, eating too much and eating the wrong foods; many of you guzzling too much hooch; still puffing away at $2.50 a pack; getting your daily exercise by lumbering from the fridge to the microwave to the couch; doing dope and bringing crack babies into the world; filling the big city emergency rooms with gunshot victims; engaging in unsafe sex and catching a deadly disease while blaming the world for not finding an instant cure.

"You and your habits, not the doctors, are the single biggest health problem in this country. If anything, it is amazing that the docs keep you alive as long as they do. In fact, I don't understand how they can stand looking at your blubbery bods all day.

"So as your president I call upon you to stop whining and start living cleanly. Now I must go get myself a triple cheesy-greasy with double fries. Do as I say, not as I do."

But for those who truly believe that doctors are overpaid, there is another solution: Don't use them.

That's right. You don't feel well? Then try one of those spine poppers or needle twirlers, or have Rev. Bubba lay his hands upon your head and declare you fit.

Or there is the do-it-yourself approach. You have chest pains? Then sit in front of a mirror, make a slit here, a slit there, and pop in a couple of valves.

You're going to have a kid? Why throw your money at that overpaid sawbones, so he can buy a better car and a bigger house than you will ever have (while paying more in taxes and malpractice insurance than you will ever earn)?

Just have the kids the old-fashioned way. Squat and do it. And if they survive, you can go to the library and find a book on how to give them their shots.

By the way, has anyone ever done a poll on how much pollsters should earn?

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Getting the job done

Singled out as being helpful, conscientious and pleasant, senior records technician Ted Johnson is April's Employee of the Month.

Johnson is at his best as a team player, said ISMS Vice President of Management Services Diana Role, in presenting the award. "Whether he is delivering files; sorting claims division mail; pulling files for underwriting, internal audit or risk management; subbing for [other staff members] on the mail runs; or doing any number of various other tasks, Ted directly impacts our members and policyholders by providing service to all who have contact with him."

Most employees are unaware of the degree of skill, knowledge and hard work the job in central files requires, she explained. Nominators cited Johnson for his "great attitude" toward his job and fellow employees. They also said he is always willing to do whatever it takes to get the job done.

"His tireless efforts enable ISMS to run efficiently," wrote one nominator.

"If internal staff worked the file room one day, they would have a greater appreciation of the tasks they perform," commented another. "He is always willing to go the extra step to help the staff."

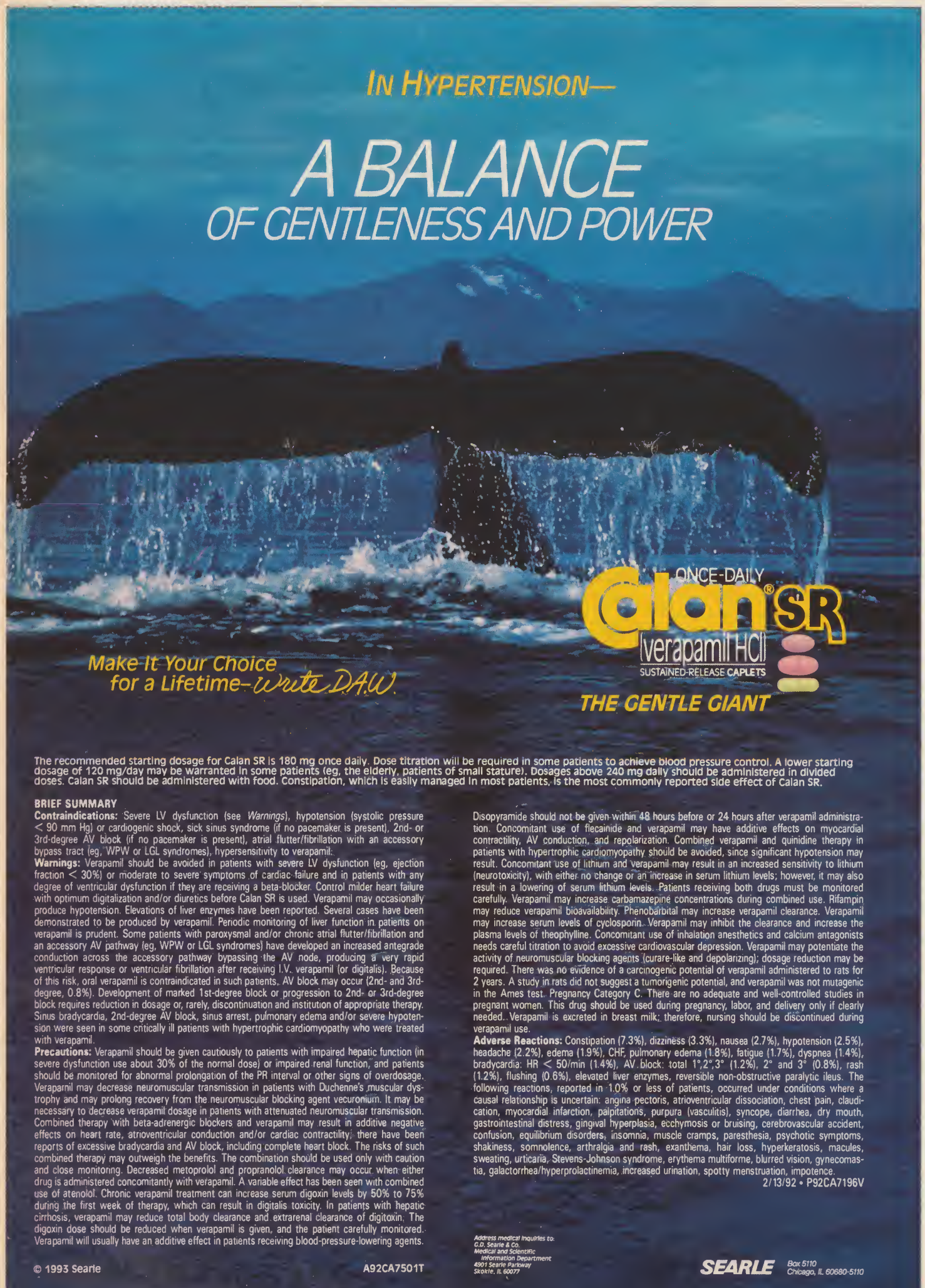
Johnson joined ISMS in 1986 as a records/file clerk and was promoted to senior clerk in 1991. "I'd like to say that this means a lot," said Johnson. "I didn't think I was being watched! I'd like to thank my nominators and the staff in central files. We do things as a team."

All permanent, full-time ISMS employees, with the exception of senior management, are eligible for the Employee of the Month award. To nominate a staff member, contact the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■



M. Candee Studios

Johnson, a senior records technician, spends much of his day looking for files.



MEMBERS IN THE NEWS



Dr. Jain

A 15-year member of the Thorek Hospital and Medical Center's medical staff, **Bhagwan Jain**, MD, of Hinsdale, has been elected to the hospital's board of trustees. Dr. Jain, a member of the medical staff since 1979, is board certified in cardiology and internal medicine and is a fellow of the American College of Cardiology.

Karen B. Weinstein, MD, of Chicago, has been elected to fellowship in the American College of Physicians, a professional organization for internists. She will be honored this month at the ACP's annual scientific session in Washington, DC.

Dr. Weinstein, a board-certified specialist in internal medicine, has been affiliated with West Suburban Hospital Medical Center in Oak Park since 1987. She has served as director of outpatient education at the hospital since 1989.

Fellowship in ACP is an honorary designation that recognizes scholarly and professional achievements in internal medicine.

David L. Nahrwold, MD, of Chicago, has been elected to the Board of Governors of the American College of Surgeons as a specialty society governor from the Society for Surgery of the Alimentary Tract. Dr. Nahrwold is surgeon-in-chief at Northwestern Memorial Hospital and chairman of the department of surgery at Northwestern University Medical School. ■

Illinois Medicine *is interested in the activities and accomplishments of ISMS members. Send information to 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.*

ISMIE Update

More Exchange changes

PAGE 11

Guidelines on liens, living wills explained

PAGE 10

Increasing incidence of HIV underlines the importance of assessing patients

As the incidence of exposure to HIV continues to increase nationwide, physicians will need the knowledge and skills to improve patient care and decrease their liability risks. By Judy Huerta

The statistics are staggering. The U.S. Centers for Disease Control and Prevention says as many as one in 100 men and one in 800 women in the United States may be infected with HIV. Heterosexual transmission of HIV, adolescent or young adult AIDS cases, and the incidence of AIDS in small and rural communities have increased and are expected to escalate.

As the epidemic continues, more physicians will encounter HIV and AIDS in their practices and the likelihood of AIDS-related malpractice claims will increase. Already, claims have been reported that allege failure to diagnose AIDS or related conditions, misdiagnosis of AIDS, or breach of confidentiality for improper release of HIV or AIDS-related patient information. Many Americans remain unaware of the significant facts regarding the transmission of HIV. Recent studies demonstrate that while they acknowledge the importance of HIV assessment, some physicians admit reluctance and minimal confidence in their ability to comfortably discuss HIV exposure, sexuality and intravenous drug use with their patients.

The CDC says as many as one in 100 men and one in 800 women in the U.S. may be infected wth HIV.

Medical and liability experts say that to do justice to their patients and to protect themselves from additional liability risks, physicians who have not already done so must acquire the necessary knowledge and skills and begin to evaluate patients for HIV exposure. The HIV assessment creates opportunities for physicians to

- Educate patients about safer sex;
- Reassure and calm low-risk, anxious patients;
- Motivate behavior changes in high-risk patients;
- Facilitate early medical intervention for infected patients;
- Enhance the doctor-patient relationship; and
- Reduce their own liability risks.

PHYSICIANS EXPERIENCED in taking HIV-exposure histories offer these suggestions to enhance a dialogue between physicians and patients:

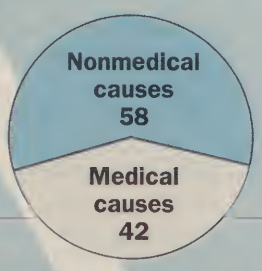
- Ask open-ended questions that must be answered with more than "yes" or "no." ("What safer sex techniques do you use?")
- Ask about high-risk behaviors, rather than high-risk groups. ("Have you had sex with men, women or both?" rather than "Are you a homosexual?")
- Phrase questions and responses in nonjudgmental words.
- Use simple terms with which you are comfortable.
- Weave questions about sexual practices, STDs and drug use into a general discussion of health.
- Ask if the patient or the patient's partner(s) have had a blood transfusion or tattoo since 1977.

(Continued on page 10)

Top five medical causes of closed ISMIE claims 1985-92

1. Errors in diagnosis
2. Improper performance
3. Failure to supervise or monitor case
4. Delay in performing procedure
5. Failure to recognize a complication of treatment

Percentage of medical & nonmedical causes of closed claims



Source: Illinois State Medical Inter-Insurance Exchange

MALPRACTICE ROUNDUP

Public opinion favors tort reform

According to statistics published by the AMA's Specialty Society Medical Liability Project, 77 percent of U.S. adults think malpractice lawsuits and awards are largely responsible for rising health care costs. Public opinion surveys of health care issues revealed that only 27 percent of U.S. adults believe that people who sue physicians for malpractice are usually justified in bringing suit, and only 27 percent believe the court system's handling of such cases is fair to doctors.

Studies also showed that more than half (54 percent) of adults think jury awards in malpractice suits are usually too high, 24 percent think the amount of money awarded is appropriate and only 6 percent think awards are too low. In addition, more than 60 percent of adults favor setting a ceiling, or cap, on pain and suffering awards in malpractice cases.

When asked if they thought medicine was a less attractive career now than 10 years ago, 39 percent of adults surveyed said yes, with two-thirds of that group citing the high cost of malpractice insurance and lawsuits as the cause. ■

Technician wins suit against AIDS patient

As reported in *Medical Malpractice Law and Strategy*, a California jury awarded $102,500 to a surgical technician who was nicked with a scalpel while removing sutures from an AIDS patient. In what may be the first tort lawsuit ever brought against a patient by a health care worker, the jury said the patient committed fraud by hiding her AIDS diagnosis from the health care workers when she had breast reduction surgery in 1991. Counsel for the patient argued that the technician, who was not wearing gloves at the time of the incident, did not follow standard precautions. The technician has repeatedly tested negative for HIV.

Although the jury also found the treating physician and medical center partly liable, the technician reportedly will seek all damages from the patient. ■

Doing favors for patients can be risky

Physicians should think twice before agreeing to help a patient with a condition they are not fully prepared to treat. In *Patient Rx Newsletter*, the Pennsylvania Medical Society Liability Insurance Company cautions physicians that a favor done at a patient's urging may return to haunt them. That's what happened to two physicians who ultimately faced malpractice suits.

In one case, a physician agreed to handle a serious condition for a patient who did not want to travel 25 miles to a regional medical center for treatment. The patient suffered some harm and filed a malpractice suit against the doctor. In another example, a surgeon found herself involved in a malpractice suit after performing an operation during which she completed two procedures because the patient refused to be placed under anesthesia more than once. ■

Guidelines on liens, living wills explained

MEDICAL LEGAL GUIDELINES

Lien regulations are included in Illinois law [770 ILCS 80/0.01 et seq. (1992)], formerly [Ill. Rev. Stat. 1991, ch. 82, pars. 101.1 - 101.6]. According to the statute, every physician who renders treatment, except services under the Workers' Compensation Act or Workers' Occupational Diseases Act, will have a lien on all claims and causes of action for reasonable charges. The total amount of all liens cannot exceed one-third the sum paid or due to the injured person on the claim or the right of action.

The statute says that the physician will give notice in writing with the name and the address of the injured person, the date of injury, the name and address of the physician, and the name of the party alleged liable. The notice will be served by registered or certified mail to both the injured person and the party against whom the claim exists. The party against whom the claim is filed, as well as any party to cause pending in court, has a right to examine the physician's records regarding the treatment of the injured person. Such must be accomplished within 10 days of being so requested in writing. If a physician refuses to furnish such records, the lien will become null and void.

THE ILLINOIS LIVING WILL ACT [755 ILCS 35/1 et seq. (1992)], formerly [Ill. Rev. Stat. 1991, ch. 110 1/2, pars. 701 – 710], passed by the Illinois General Assembly in 1983, gives individuals the right to execute a "living will," or "declaration," about end-of-life decisions. The document instructs patients' physicians to withhold or withdraw death-delaying procedures from patients with terminal conditions, according to patients' wishes. Individuals may execute either a living will, a durable power of attorney for health care or both.

A living will generally indicates patients' health care decisions in cases of terminal illness. A durable power of attorney for health care authorizes agents designated by patients to act as the patients would in managing their own medical affairs. When both documents are executed, the durable power of attorney takes precedence if the agent is available.

If there is no living will or durable power of attorney, guidelines outlined in the Health Care Surrogate Act may be followed. The Act, passed by the legislature in 1991, provides guidelines for patients who want to refuse life-sustaining care.

For more information on advance directives, consult the medical legal guidelines on durable power of attorney and surrogates, which discuss the Illinois Power of Attorney for Health Care law [755 ILCS 45/4-1 et seq. (1992)], formerly [Ill. Rev. Stat. 1991, ch. 110 1/2, pars. 804-1 – 804-12] and the Illinois Health Care Surrogate Act [755 ILCS 40/1 et seq. (1992)], formerly [Ill. Rev. Stat. 1991, ch. 110 1/2, pars. 851-1 – 851-55]. Physician responsibilities under the Living Will Act can be found in the ISMS reference piece for doctors, "A Physician's Guide to Advance Directives," and the patient-oriented publication about advance directives, "A Personal Decision." ■

Editor's note: This is part of a series on medical-legal issues written by the ISMS Medical Legal Council. These guidelines do not necessarily represent ISMS policy. They address legal concerns that physicians most commonly express to ISMS and are intended to serve as only a general guide for physicians, not specific legal advice.

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HIV

(Continued from page 9)

- Ask whether the patient has had sex with prostitutes or an intravenous drug user.
- Provide safer-sex literature for patients.
- Offer both pre- and post-HIV-test counseling.
- Discuss test results in person and have a concrete plan to provide or suggest medical, emotional or psychiatric follow-up to HIV-positive patients.

Patients will appreciate and benefit from the concern and expertise of physicians who assess for HIV exposure. Physicians who make that evaluation will decrease their liability risks. ■

Judy Huerta is a loss prevention coordinator at the Medical Insurance Exchange of California. This article is reprinted with permission from Judy Huerta and the Medical Insurance Exchange of California.

Exchange changes

(Continued from page 1)

and for orthopedic surgeons who perform back surgery. Dermatologists will drop from Class 1 to Class 0, lowering their rates by 28 percent for the 1993-94 policy year. Orthopedic surgeons rated in Class 6A will pay 8 percent less this year as a result of a class relativity adjustment. The special 6A classification was created to better serve back surgeons.

Physician policyholders in Vermilion County will also see lower liability premiums this year, when they move from Territory IA to Territory II. Downward loss trends spurred the 11-percent premium reduction.

Responding to increasing malpractice awards, the Exchange is eliminating the lowest coverage limits of $250,000/$750,000. This change protects physicians who have carried these limits and were underinsured, Dr. Jensen explained. Before dropping these limits, the Exchange contacted physicians who carried them and helped them select alternatives.

Indemnity payments are rising, even in lower-rated territories and lower-risk specialties, he noted. For example, the average 1992 payout was $350,000, compared to $270,000 in 1989 and $130,000 in 1982. "When a physician carries low limits, the aggressive defense of a claim is compromised. Even if a claim is defensible, the risk of an adverse verdict forces the Exchange to settle it within the policy limits."

This dramatic increase in payouts forced the Exchange to raise base premiums for policyholders by 5 percent for the upcoming policy year. This increase is in line with industry trends and is the first increase the Exchange has taken in several years. Although actuarial projections compiled for the Exchange indicated a need for steeper rate increases to cover higher indemnity payments, the company's service initiative, Physician First Service, helped keep the increase modest, Dr. Jensen said.

This year, the Exchange also introduced a 5-percent assessment for those physicians with payouts during the past three years as policyholders.

Another positive policy change has been enacted for physicians who work with paramedical employees. A new rating system will include paramedical rates as part of the overall corporate rate physicians pay if their work, when appropriately supervised, does not represent significant risk for their physician employer. Separate charges will be retained, however, for some categories of paramedical workers such as certified nurse-midwives and nurse-anesthetists. ■



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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

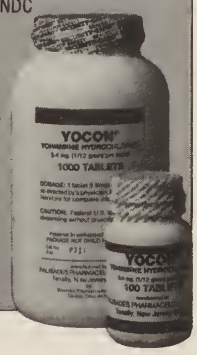
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Recently board-certified family practitioner needs position within 100 miles of Chicago area. Procedure-oriented and need to do some obstetrics and inpatient and some ICU patient care. Hospital managed preferred. Please send replies to Box 2242, % *Illinois Medicine*, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

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Tort reform

(Continued from page 1)

tort cases, not just medical malpractice, and would generally increase health care costs and the cost of doing business in Illinois.

A bill of particular concern, H.B. 1369 would amend the Code of Civil Procedure by allowing a plaintiff to file a pleading against a fictitious person or entity, while naming an actual person or entity as a respondent in discovery. The bill would allow discovery to begin in lawsuits that lack actual defendants. Current law requires at least one real defendant in lawsuits and mandates that plaintiffs in medical malpractice cases obtain a certificate of merit signed by a third-party physician. Naming physicians as respondents in discovery when no actual defendant exists could essentially nullify the affidavit requirement, according to legislative analysts. An identical bill, S.B. 18, sponsored by Sen. John Cullerton (D-Chicago), was defeated in committee.

Meanwhile, in the Senate, ISMS is supporting S.B. 372, sponsored by Sen. Peter Fitzgerald (R-Palatine). The bill would prohibit a 90-day extension for plaintiffs in malpractice actions to file required certificates of merit if they voluntarily dismissed a malpractice action and began a new action within one year. S.B. 372 was passed by the Senate April 15 and will advance to the House. Also before the Senate is the centerpiece of ISMS-supported tort reform, S.B. 344, a $250,000 cap on noneconomic damages.

Another bill advancing is S.B. 447, introduced by Sen. David Barkhausen (R-Lake Forest). The bill would allow physicians and other health care practitioners facing malpractice suits to discuss the care provided to their patients with their own legal counsel, malpractice insurer, present or former employer, principal partnership, or professional corporation.

THE SOCIETY OPPOSES H.B. 552, sponsored by Rep. David Phelps (D-Eldorado), which would authorize birthing centers as alternative health care models. The bill advanced to the House floor. ISMS House of Delegates policy supports the creation of model birthing centers only if they meet certain requirements, such as fulfilling state certificate of need criteria, maintaining peer review, and creating proper credentialing and quality assurance processes. In addition, House of Delegates policy supports such centers only if they also adhere to American College of Obstetricians and Gynecologists guidelines, such as the requirement that birthing centers be attached to hospitals. An identical bill, S.B. 228, sponsored by Sen. Karen Hasara (R-Springfield), also advanced.

Two mandatory assignment bills – H.B. 1504 and H.B. 1505 – sponsored by Rep. Jan Schakowsky (D-Evanston) advanced out of committee, while two others stalled. A Senate bill also remained in committee. H.B. 1504 would require physicians to notify patients if they do not accept assignment of Medicare charges. The measure also calls for double recovery if physicians fail to notify their patients. H.B. 1505 would require hospitals to notify patients if physicians who provided elective surgery services do not accept Medicare assignment charges. It also advocates double recovery if notice is not given to patients.

> ***Physicians have already seen legislative successes this session on several issues, including the demise of bills extending medical staff privileges to clinical psychologists and expanding practice definitions for optometrists.***

Under H.B. 2048, introduced by Rep. Carol Ronen (D-Chicago), nurse-specialists would be allowed to enroll with the Illinois Department of Public Aid as primary care providers to pregnant women and children. In addition, certified nurse-midwives and certified nurse-practitioners would be directly reimbursed by IDPA at the same rate as physicians. The bill is on the House floor. ISMS opposes it because it essentially allows nurse-specialists to act as physicians even though they lack the necessary medical training. A similar Senate bill, S.B. 608, sponsored by Sen. Jim Rea (D-Christopher), did not advance.

Introduced by Rep. Daniel Burke (D-Chicago), H.B. 1957 would create the Acupuncture Practice Act. The bill, which passed out of committee, would allow the licensing and regulation of the practice of acupuncture. ISMS opposes this legislation because it would allow nonphysicians in Illinois to diagnose and treat diseases and to practice other acupuncture techniques. ISMS House of Delegates policy stipulates that only physicians should practice invasive medical procedures.

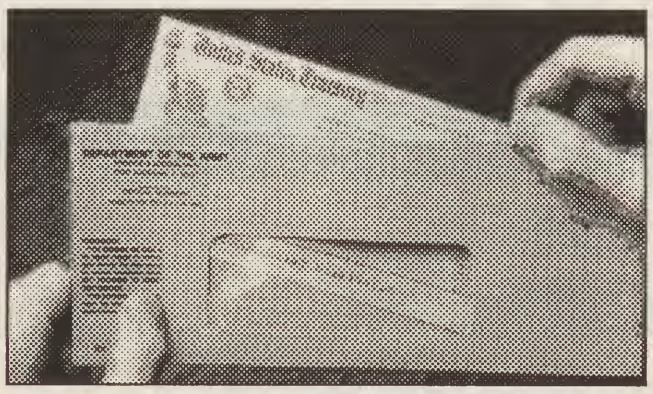
PHYSICIANS HAVE ALREADY seen legislative successes this session on several issues, including the demise of bills extending medical staff privileges to clinical psychologists and expanding practice definitions for optometrists. H.B. 1573, introduced by Rep. Jeffrey Schoenberg (D-Wilmette), was placed on the House study calendar, effectively ending clinical psychologists' chances for obtaining greater hospital staff privileges this year. Those privileges would include the ability to admit patients. An identical Cullerton-sponsored Senate bill, S.B. 640, was referred to the Senate Rules Committee.

The optometrists' bill, S.B. 333, introduced by Sen. Frank Watson (R-Carlyle), which would have allowed optometrists to prescribe therapeutic drugs, drew intense lobbying from both optometrists and physicians. After legislators heard testimony from both sides, the bill failed to receive a second and remained in committee.

A recent Illinois Supreme Court ruling allowing physicians to practice medicine until disciplinary actions filed against them by the Illinois Department of Professional Regulation are resolved is the target of H.B. 1971, introduced by Rep. Joseph Kotlarz Jr. (D-Chicago). ISMS strongly supports the legislation, which advanced to the Senate floor. The bill would allow a stay of a disciplinary action only when it can be proved that the individual poses no threat to the general public. S.B. 601, an identical bill sponsored by Fitgerald, also advanced. ■

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Putting patients first

(Continued from page 1)

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Public health bills

(Continued from page 1)

more restrictive licensing, school education programs and legislation to remove handguns from public play areas, day care centers and schools. H.B. 91 and S.B. 40 failed to advance.

Legislators once again shot down a bill mandating the use of helmets for all motorcycle drivers and passengers. S.B. 69's defeat in committee leaves Illinois one of only a few states without a helmet law on the books. The bill was sponsored by Sen. John Cullerton (D-Chicago), who has been trying to enact such legislation for several years. Longstanding ISMS House of Delegates policy actively supports legislation mandating the use of motorcycle helmets to help reduce the frequency and severity of head injuries. The issue could resurface later in the session because Illinois could lose federal funds without such legislation.

Last year, ISMS led the charge to create legislation regulating tanning parlors and creating a facility licensing fee of $250. This year, three bills were introduced to alter that law. H.B. 435, sponsored by Rep. Gary Hannig (D-Gillespie); H.B. 577, sponsored by Rep. Phil Novak (D-Kankakee); and S.B. 758, sponsored by Sen. Vince Demuzio (D-Carlinville) – all call for fee structures that smaller facilities with fewer beds believe to be more equitable. The Senate bill is essentially dead in committee, but both House bills advanced to the floor for further debate. Specifically, H.B. 435 would reduce the annual permit fee and would restrict customers to using a tanning bed once per calendar day. H.B. 577 would decrease the permit renewal fee for facilities with fewer than three tanning beds. ISMS is studying the bills, which would not conflict with Society policy endorsing tanning parlor regulation provided the proposed licensing fee restructuring does not diminish funds available for regulation.

H.B. 521, which passed out of committee, would require children's school health exams to include TB tests. ISMS is studying H.B. 521 – one of several bills addressing health screenings for schoolchildren. The impetus behind H.B. 521, sponsored by Rep. Clement Balanoff (D-Chicago), and a similar bill, H.B. 928, sponsored by Rep. Monique Davis (D-Chicago), is the poor health conditions in some of Chicago's inner-city communities. However, physicians have argued that such testing should be used only when lead exposure is indicated and should not be required throughout the state. ISMS opposed H.B. 928 in its original form because it advocated requiring all students to receive lead poisoning screenings in grades three, six and eight. The bill was amended so that screening intervals correspond with the other routine screenings performed on children in grades K, five and nine.

Introduced by Sen. Judy Baar Topinka (R-North Riverside), S.B. 846 is similar to H.B. 521 in that it calls for mandatory TB tests for schoolchildren, but S.B. 846 specifies testing in only certain areas of the state. This difference would allow physicians practicing in areas without incidences of TB to use their medical judgment in forgoing such tests. ISMS is studying the bill, which advanced to the Senate floor, to see if it will be amended to resemble H.B. 521. ■

Contacting your state legislators

The spring 1993 legislative session is well under way, but there is still time for physicians and Auxiliary members to express their views on bills of interest to medicine, such as health care reform, tort reform and public health policies.

Usually, letters and phone calls to lawmakers' offices best indicate what constituents want. A quick way for busy ISMS members to contact their legislators is by phone. When the General Assembly is in session, call the state Capitol operator at (217) 782-2000 and ask for the legislator's office. When the legislature is not in session or is on a holiday break, physicians should call their legislators' district offices. Never call a legislator at home.

If doctors are uncertain about their senator or representative's name, they may contact the ISMS governmental affairs division at (312) 782-1654 or (800) 782-ISMS. In addition, ISMS and Auxiliary members may check the legislator information packet recently provided by the Society. Included in the package are customized wallet and Rolodex cards listing each physician's state senator and representative and their Springfield phone numbers.

When calling about a particular issue, physicians should ask to speak to the specific legislator, ISMS recommends. If he or she is unavailable, leave a brief message with a staff member or secretary, stating the bill number and your position. Do not leave a long explanation unless specific questions are asked. For example: "I would like to let Rep. Smith know that I strongly oppose House Bill 1459. I would like to ask him to vote no on this bill." It is also always beneficial to state how a particular piece of legislation would affect the health care of patients in legislators' districts.

Letters are also effective. State the letter's purpose in the first paragraph, and identify legislation both by House or Senate origin and by number – for example, H.B. 1459. Letters need not be typed, but must be legible, and should be kept to one page if possible. All letters should be signed and include your address. ■

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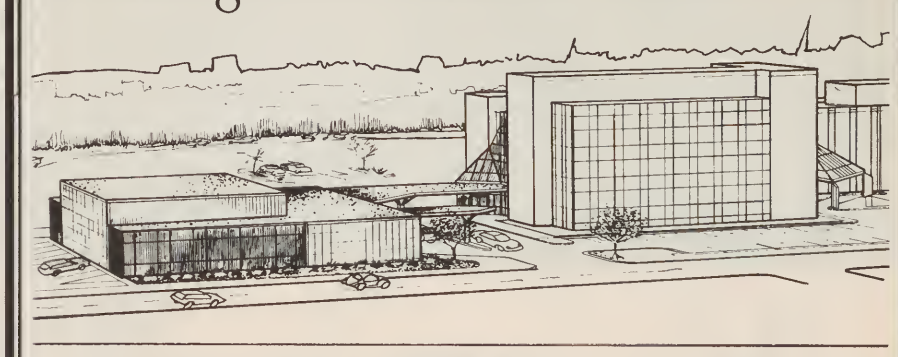
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SERVI S (PAGE 9)



Orchestrating the players in rehabilitation
PAGE 12

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MAY 7 1993

They're here: CLIA office inspections are under way
PAGE 2

ISMS-backed measures advance in legislature

CAPS BILL MOVES: Physician issues hang tough as the legislative session rolls on. By Anna Brown

[SPRINGFIELD] Affirming medicine's strong presence in Springfield, some ISMS-supported legislation is advancing well into the legislative season, including a cap on noneconomic tort awards. As *Illinois Medicine* went to press, a number of bills introduced on behalf of ISMS had either advanced from their respective houses or were poised to do so.



Sen. McCracken

The centerpiece of ISMS-supported tort reform, S.B. 344, sponsored by Sen. Thomas McCracken Jr. (R-Westmont), advanced from the Senate April 20. S.B. 344 would cap noneconomic tort awards, including medical malpractice damages, at $250,000. The bill's advancement is a preliminary success for Illinois physicians weathering an uncertain malpractice climate. S.B. 344's momentum in the Senate does not, however, guarantee an easy passage in

(Continued on page 5)

Rural health measures seek to expand access to care

UNDERSERVED AREAS: Legislators and rural health advocates attempt to gain funding for programs around the state. By Anna Brown

[SPRINGFIELD] State legislators have been debating an issue of pressing importance to physicians and patients in rural Illinois: access to care in their communities. The specifics about implementation of legislative remedies had not yet been determined as *Illinois Medicine* went to press. Still up for debate in their respective houses are several bills and a resolution.

H.B. 1693, sponsored by Rep. David Phelps (D-Eldorado), would appropriate funds for programs created in a 1990

(Continued on page 18)

INSIDE

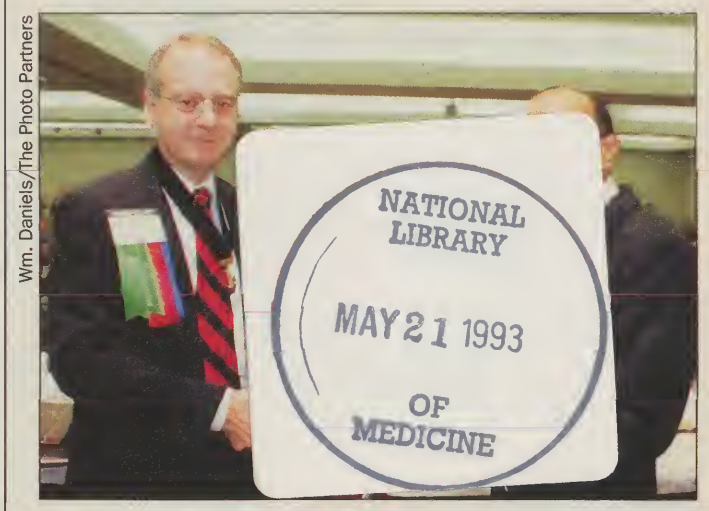
Physicians respond to the high cost of pharmaceuticals
PAGE 3

Health measures stir debate in House, Senate
PAGE 4

H.B. 1459 roll call
PAGE 17

DEPARTMENTS

News Briefs.....2
Commentary.....6
ISMIE Update.....9
Classifieds 15



Wm. Daniels/The Photo Partners

NEWLY INDUCTED ISMS PRESIDENT Arthur R. Traugott, MD (left), honors Immediate Past President Arvind K. Goyal, MD, during an April 25 ceremony. Dr. Traugott, an Urbana psychiatrist, assumed the ISMS presidency during the 1993 House of Delegates Annual Meeting in Oak Brook April 23-25. During his tenure, Dr. Traugott will travel throughout Illinois serving as the Society's spokesperson.

Governor's task force begins work on health reform

UPDATE: The Illinois task force measures progress in Washington and prepares for its next phase of operation. By Gina Kimmey

[CHICAGO] For the first time since submitting its Medicaid assessment recommendations in February, Gov. Edgar's Health Care Reform Task Force met April 12 to review its progress and begin working on health reform in Illinois. The group has broken into five subcommittees, each responsible for examining and recommending aspects of a state reform plan.

Four of the groups – the Long-term Care, Access, Finance and Managed Care committees – have met and formulated mission statements. The Malpractice Reform Committee should be "up and running" soon, said Ernie Wish, task force chairman and a retired consultant with health care experience.

Chaired by Sally Jackson, president of the Illinois State Chamber of Commerce, the Long-term Care Committee adopted the mission to recommend a plan that ensures a "viable system [that] accommodates a growing demand and offers access to a continuum of affordable, cost-effective, quality long-term-care services. ..." The committee believes any reform plan must ensure broad access and manageable costs, and encourage private-sector financing, Jackson said.

Faced with the challenge of ensuring the availability of health care for all citizens, the

(Continued on page 19)

ISMS PERSPECTIVE

ILLINOIS HOUSE DEFEATS H.B. 1459

Organized medicine scored a legislative victory April 22 when the Illinois House failed to advance a health reform proposal advocating a government-controlled health delivery system. H.B. 1459, sponsored by Rep. Bill Edley (D-Macomb), garnered only 57 of the 60 votes necessary for passage. The bill was modeled after Vermont's health reform plan.

"We commend the House for making the wise decision to defeat this reform proposal," said ISMS President Arthur R. Traugott, MD. "The legislature obviously saw the implications of this bill. Although it seemingly called for only a study of two government-run reform options, in reality the measure mandated implementation of a system that would have created drawbacks for patient care, such as expenditure caps and global budgeting."

Although ISMS supports universal access to health care for all Illinois patients, the Society opposed the so-called Health Security Act because the health delivery system options it advocated would have been over-

(Continued on page 19)

No intermission for smokers

[PEORIA] Because of the dangers associated with secondhand and sidestream smoke from cigarettes, the Peoria Medical Society has recommended that smoking and the use of tobacco products be prohibited within the confines of the Peoria Civic Center, including corridors, rest rooms and stairways.

"That smoking is still allowed in the Peoria Civic Center corridors around the arena, exhibition hall and theater is surprising with the data available showing the ill effects on nonsmokers," said Maqbool B. Ali, MD, president of the Peoria Medical Society. "While the Peoria Civic Center would not be the first such facility to establish a no-smoking policy, such a policy would certainly help to show that we here in Peoria are progressive and understand the needs of everyone, especially the 75 percent of the population who don't smoke."

Recent studies have documented secondhand smoke as a cause of lung cancer, and cardiovascular and pulmonary problems in nonsmokers.

Dr. Ali said that Peoria has been a leader in the health care field for years and that initiating this policy would protect nonsmokers from exposure to noxious substances. In addition, such a policy represents preventive medicine, which is a "much more efficient and cost-effective way of approaching health care than treatment of actual illness." ■

They're here: CLIA office inspections are under way

NOTICE: After years of looming in the distance, CLIA's quality control program is descending on physicians with office-based labs. By Gina Kimmey

[SPRINGFIELD] It's show time for Illinois physicians with office-based laboratories. April 8 marked the beginning of office-based lab inspections under the federal CLIA regulations. As previously reported in *Illinois Medicine*, IDPH, working as an agent of HCFA, will be conducting all lab inspections.

According to an IDPH spokesperson, only those labs conducting moderately or highly complex tests will be inspected. Physicians will receive three days' notice and should be prepared to produce procedural manuals, quality control and quality assurance records, and documentation of all personnel records.

Richard J. Sassetti, MD, a member of the ISMS Medical Services Committee, said that CLIA is, in two words, quality control. "The third word is adherence. The most frequent cause of a citation will be a doctor's failure to follow a procedure as it is written in the manual," Dr. Sassetti said. He stressed that manuals should be kept current. When an accepted procedure is modified, it should be changed in the manual as well.

Physicians whose office-based labs are cited for deficiencies will be instructed to submit a plan of action for correcting the inadequate procedures. No sanctions or fines will be imposed at this stage.

Dr. Sassetti recommends that physicians concerned about compliance refer to the ISMS-produced CLIA handbook. "The best way for physicians to prepare is to check themselves against the section on quality control in the ISMS handbook. They could also get a copy of the procedural manual and conduct a self-inspection."

First offered to physicians in October 1992, the handbook "Clinical Laboratory Improvement Amendments: What You Should Know" was developed by the ISMS Council on Medical Services and the Committee on Blood Banking and Laboratory Services. Physicians who are interested in obtaining a copy or have questions about CLIA may contact the ISMS medical services department at (312) 782-1654 or (800) 782-ISMS. ■

JCAHO plans surprise hospital surveys

[CHICAGO] The Joint Commission on Accreditation of Healthcare Organizations will begin conducting unannounced one-day surveys of accredited hospitals July 1. Recently approved by JCAHO's executive committee, the surveys could affect about 160 hospitals, nursing homes, home-care programs and mental health facilities in the middle of three-year accreditations. According to the March 22 issue of *Physicians Weekly*, surveyors will evaluate areas in which JCAHO found the most problems last year – life-safety, safety management, credentialing, infection control and governance.

JCAHO President Dennis O'Leary, MD, said, "The intended effect of random, unannounced surveys is to shift organizational attention away from a triennial storm of preparatory activities to a state of constant preparedness." ■

General Assembly clarifies EMS Systems Act

[SPRINGFIELD] Legislation clarifying the Illinois Emergency Medical Services Systems Act passed the General Assembly this session. The legislative action became necessary when it came to light in March that a section of the EMS Systems Act had been omitted through a publishing error.

Originally enacted in 1980, the law included a provision sunsetting the Act in 1986. But this portion of the Act was never published.

"Because the services provided under this Act are so important, and even though we believe the law continues to be fully enforceable, there is no room for even the slightest ambiguity about the continued validity of it," said Gov. Jim Edgar, in bringing the omission to the attention of the state's legislative leaders. ■

Urban health leaders to meet in Chicago

[CHICAGO] Health department leaders of the 40 largest U.S. metropolitan areas will get a Taste of Chicago and a taste of the windy city's health department success stories when they meet June 28 and 29 for the Chicago Department of Health's first annual Big City Health Conference.

"We have some fairly innovative programs in the Chicago Department of Health, and we wanted to create a forum to share them with others," said Frances Ginther, CDOH health regulations director and the conference's principal organizer. "We also wanted to get other big cities to share their programs with each other.

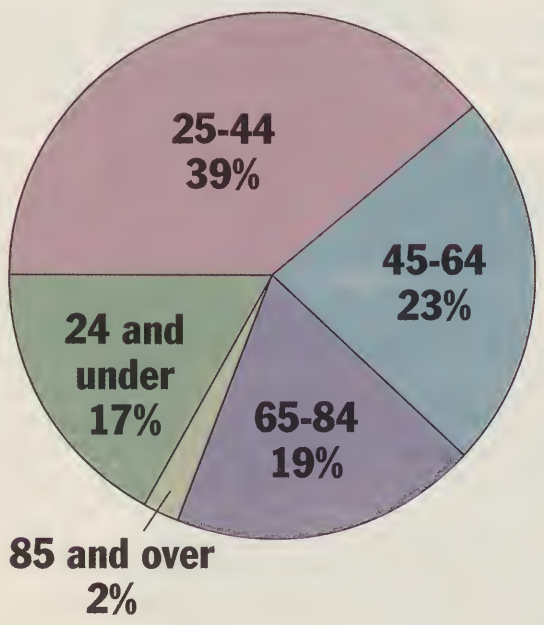
"This conference will focus just on problems and concerns that are unique to large metropolitan areas," Ginther added. "We can all get together in one spot very quickly and talk about programs and ideas that will benefit 15 percent of the nation's population. And the coalition we create will go on into the future."

The conference, funded in part by a grant from Marion Merrell Dow Inc., will include presentations by public health experts, interactive workshops and information on CDOH successes in childhood immunizations, tuberculosis, sexually transmitted diseases, chronic diseases, nutrition, laboratory services, injury control and health education.

The Clinton administration's proposed changes in the health care system and their effect on large municipal health departments will also be a highlight of the conference. ■

PHYSICIAN FACTS

Suicides by age in the United States



Source: National Center for Health Statistics, 1990

Saint Anthony's announces oncology expansion

[ROCKFORD] Saint Anthony Medical Center has announced its plan to build a comprehensive clinical oncology center. The full-service center will offer prevention and detection services; radiation therapy; on-site pharmacy, dietary, laboratory and counseling services; and a multidisciplinary team of oncologists, oncology nurses, radiation oncologists and radiation therapists.

Groundbreaking for the new center, expected to cost $8 million for construction and facility equipment, is scheduled to begin this summer. Hospital officials estimated construction will take about one year.

Opening the center would fill a void noted by the Illinois Health Facilities Planning Board, which stressed a need for cancer treatment facilities in the region to treat the growing number of cancer patients. Currently, the nearest such comprehensive facility is in Chicago. ■

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Physicians respond to the high cost of pharmaceuticals

PRICING POLICIES: Illinois doctors question one drug company's defense of the rising costs in its industry. By Gina Kimmey

[CHICAGO] Pharmaceuticals accounted for 30 percent of out-of-pocket health care costs in 1990, according to government statistics. And as patients become more concerned about drug prices, so do the physicians who care for them.

For example, physician delegates at the 1993 ISMS Annual Meeting adopted a Board of Trustees report calling for continued support of the AMA's ongoing efforts to influence drugmakers to reduce costs by whatever means possible.

Defending the pharmaceutical makers' role in America's soaring health care costs, representatives from Chicago-based Searle addressed an April 1 meeting of the ISMS Council on Economics. The pharmaceutical industry has joined doctors as the media's "public enemy No. 1," said Tom Norton, Searle's director of public and governmental affairs.

The R & D costs on an older drug would have been amortized over its time on the market, so its costs shouldn't be rising, yet they are.

Norton said the U.S. pharmaceutical industry invested $13 billion in research and development last year and owns 82 percent of the world's biotechnology and pharmaceutical patents. Development costs for each new drug average $400 million, he said, adding that only one in 5,000 chemically synthesized drugs is FDA approved and ultimately reaches the market.

"Seven out of 10 drugs [that reach the market] will not return on their R & D investment. A company relies on that one blockbuster drug to make up the difference," Norton said.

After listening to Searle's presentation, replete with charts and graphs, several council members remained concerned about drug prices. Council Chairman Norman J. Scheibling, MD, a Springfield insurance medicine specialist, said he understands the industry has a severe image problem, but questions its pricing policies.

"Are older drugs subsidizing newer drugs? I believe so," Dr. Scheibling said. "The R & D costs on an older drug would have been amortized over its time on the market, so its costs shouldn't be rising, yet they are."

The council told the Searle officials it would review and comment on any industry-developed initiatives designed to limit drug prices.

Dr. Scheibling also raised questions about pharmaceutical advertising, calling prescription drug ads on commercial television inappropriate. In response, Norton said Searle has refrained from commercial advertising and predicted that the entire industry may be re-evaluating that kind of advertising.

Pointing to federal requirements such as the Omnibus Budget Reconciliation Act of 1990, Norton said drug companies spend up to $6.5 billion a year satisfying government mandates. Norton and Ed Donovan, Searle's director of R & D finance, told the council that federal mandates are one reason European markets are able to sell pharmaceuticals at a lower cost. In addition, they claimed that after adjusting for variances in the value of foreign currency, U.S. drug expenditures are in line with other countries' spending.





Drs. Scheibling (left) and Orlowski considered high drug costs during a recent meeting with industry representatives.

But as a physician who sees herself as a "common American," River Forest internist Janis M. Orlowski, MD, said she doesn't buy the pharmaceutical industry's "financial hocus pocus. I don't want to see charts

(Continued on page 18)

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REPORT FOR *Illinois Physicians*

MEDICARE

Medicare Part B is responsible for developing Medicare medical coverage policies on new drugs, diagnostic equipment, treatment devices, and procedures. About 20% of them are developed by HCFA Central Office for national application, and 80% are created by local carriers. Requests for a policy may come from physicians, suppliers, manufacturers, or pharmaceutical companies. Occasionally, an existing medical coverage policy is challenged as being outdated and requiring revision.

The process that Medicare Part B in Illinois uses in developing new or revised medical coverage policies can be complicated and time-consuming. It involves reviewing:

- HCFA rules and regulations to determine if there is a national policy.
- Blue Cross Blue Shield Association Technology Evaluation and Coverage Program (TEC) documents to determine if the new drug, equipment, device or procedure is supported as being effective in the medical literature.
- Publications of the FDA to obtain verification that a new drug, equipment or device is approved.
- Pertinent medical literature.
- Publications from one of several Technology Assessment Groups in the nation.
- Policy on the subject by Blue Cross and Blue Shield of Illinois.
- Policies of other carriers in Region V and any other carriers that we are aware have made policies on the subject.
- Comments on the proposed policies from the Illinois State Medical Society, the Illinois Association of Osteopathic Physicians and Surgeons, the Peer Review Organization and all state-wide Specialty Societies. This is currently managed by submitting drafts of new or revised policies to the Carrier Advisory Committee members who represent the ISMS, the IAOPS, the PRO and all specialty societies in Illinois. The above societies are allowed 45 days to approve, disapprove, or suggest revisions in the proposed policy.
- The AMA's CPT and the HCPCS Level II listing for a code for the item or procedure.

After this review, if the Medicare Medical Directors determine that the service is not experimental/investigational, is of benefit to Medicare patients, and is becoming standard of care in this area, the policy is submitted to our Operations Committee. This committee develops the necessary protocols so that the new policy is integrated into our computer systems and operational procedures.

The last step in the process is to publish the policy in the Medicare B Bulletin informing the physician community that the policy will become effective 30 days from date of publication.

(Issue: 05/07/93 - MedB)

Health measures stir debate in House, Senate

LEGISLATION ROUNDUP: A variety of bills affecting the practice of medicine are being debated in Springfield. By Anna Brown

[SPRINGFIELD] As the spring legislative session gains momentum, an assortment of bills affecting medicine have advanced. At press time, ISMS was carefully watching the progress of several bills.



The House advanced a bill April 22 that would make blocking access to a medical facility a Class B misdemeanor. H.B. 57, sponsored by Rep. Jeffrey Schoenberg (D-Wilmette), was introduced in response to abortion clinic protests and recent violence against physicians who perform abortions. ISMS House of Delegates policy urges medicine to take an active interest in apprehending and prosecuting individuals who assault physicians. Actions would include offering rewards and other incentives, and asking the AMA to seek federal legislation on this policy.

The Illinois House also approved a bill that would require health care professionals who perform abortions on minors to give parents 48 hours' notice of the procedure. ISMS is studying H.B. 1300, sponsored by Rep. Terry Parke (R-Schaumburg), and its companion Senate bill, S.B. 209, introduced by Sen. Thomas McCracken Jr. (R-Westmont). At the 1993 Annual Meeting, the ISMS House of Delegates defeated a resolution calling for the Society to oppose legislation allowing minors to bypass parental notification when seeking abortion services.

An immunization bill, S.B. 712, sponsored by Sen. Alice Palmer (D-Chicago), advanced. ISMS does not oppose S.B. 712, which arrived in the House April 16. The bill would require the state public aid and public health departments to establish pilot programs providing walk-in immunization services for children at local public aid offices.

ISMS opposed H.B. 1323, sponsored by Rep. Judy Erwin (D-Chicago), which would have amended the College Student Immunization Act by exempting off-campus residential students from the Act's provisions. Although the bill advanced out of committee, it lost on third reading in the House April 13.

A BILL INITIATING a hypodermic needle exchange and an AIDS education program advanced to the House floor. H.B. 2063, introduced by Rep. Barbara Flynn Currie (D-Chicago), seeks to curb the spread of HIV by starting needle exchange programs in Cook, Kane and Winnebago counties, the three Illinois counties with the highest number of AIDS cases attributed to IV drug use. An identical Senate bill, S.B. 256, sponsored by Sen. Donne Trotter (D-Chicago), failed to advance.

S.B. 257, also sponsored by Trotter, would have allowed individuals to purchase 10 hypodermic needles at a time. S.B. 732, introduced by Sen. Jesus Garcia (D-Chicago), would have created the Needle Exchange Program Act. Neither of these bills advanced.

ISMS no longer opposes legislation that would have promoted treatment programs for pregnant drug abusers, but would have included punitive provisions. H.B. 383, sponsored by Rep. Al Salvi (R-Wauconda), as originally written, had called for punitive actions against pregnant women who knowingly or intentionally used a dangerous narcotic drug that would cause their babies bodily harm or death. Specifically, charges lodged against women who harmed their children through drug abuse would have been Class A misdemeanors on the first offense and Class A felonies on subsequent offenses. However, these punitive provisions, opposed by ISMS, were removed by amendment.

Several AIDS-related Senate bills opposed by ISMS died in committee. Sen. Margaret Smith (D-Chicago) sponsored three bills dealing with confidentiality issues. ISMS policy supports the principle of safeguarding patients' privacy and confidentiality, while recognizing the need for some "enforcement activities in the public good." S.B. 115 would have banned health care providers from requiring HIV tests for patients seeking treatment for unrelated conditions or from requiring disclosure about previous HIV tests. S.B. 116 would have banned physicians from performing HIV tests on patients who have consented to other tests, but who have not specifically consented to HIV testing. And S.B. 305

(Continued on page 14)



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ISMS-backed bills

(Continued from page 1)

the House. The bill was assigned to the House Rules Committee, and legislative analysts predict the bill may not be called for a vote. The House already soundly defeated S.B. 344's companion bill, H.B. 1432, sponsored by Rep. Tom Ryder (R-Jerseyville), in committee earlier in the session.

"The Illinois State Medical Society supports fairness and justice in our legal system," said new ISMS President Arthur R. Traugott, MD. "A $250,000 cap on noneconomic awards will contribute to that objective, as well as help create access to affordable basic medical care for all."

Dr. Traugott explained that arbitrary jury verdicts have encouraged a "go-for-it-all" attitude, regardless of the magnitude of injuries sustained. "Our legal system was intended to fairly compensate those truly injured through the negligence of others," he said. "Often the system prevents the injured from receiving just compensation, while others reap windfalls."

In addition to ISMS, proponents of caps legislation include the Illinois Hospital Association, the American Insurance Association, the Illinois Manufacturers' Association, the Illinois Municipal League and businesses. Its opponents include the Coalition for Consumer Rights, the Illinois AFL-CIO, Illinois Public Action, the Illinois State Bar Association and the Illinois Trial Lawyers Association.

OTHER ISMS-SUPPORTED MEASURES are also advancing. H.B. 1971, a bill prohibiting stays of disciplinary actions under certain conditions, moved from the House to the Senate floor April 14. The bill was introduced by Rep. Joseph Kotlarz Jr. (D-Chicago) in the wake of a recent Illinois Supreme Court ruling allowing dentists to continue practicing dentistry until resolution of disciplinary actions filed against them by IDPR and completion of all administrative and court appeals. The bill would allow stays of disciplinary actions only when it could be proved that individuals posed no threat to the public. The Senate passed an identical bill, S.B. 601, sponsored by Sen. Peter Fitzgerald (R-Palatine).

ISMS is also supporting Fitzgerald's S.B. 372, which advanced to the House April 15. The measure would prohibit a 90-day extension for plaintiffs in malpractice actions to file required certificates of merit if they voluntarily dismissed a malpractice action and began a new action within one year. Identical House legislation, H.B. 1972, sponsored by Rep. Judy Biggert (R-Westmont), was placed on interim study.

Another ISMS-endorsed House bill that advanced to the Senate is H.B. 1974, introduced by Rep. Edgar Lopez (D-Chicago). The bill would amend the Medical Practice Act of 1987 by allowing visiting physicians to demonstrate or perform, in addition to study, certain subjects or techniques.

S.B. 180, sponsored by Sen. John Cullerton (D-Chicago), would amend the Child Passenger Protection Act by requiring all children – even nonresidents – to wear appropriate safety restraints while traveling in Illinois. The measure advanced from committee to the Senate floor.

Another bill that reached the Senate floor is S.B. 603, which would establish a $100 fee for individuals who renew their medical license within 12 months of its expiration date. The bill was introduced on behalf of ISMS to ensure that physicians who are issued a license during the last year of the renewal cycle would not have to pay two full $300 licensure fees within the same year. The $300 fee would remain the same for other renewals.

Sponsored by Rep. Mary Flowers (D-Chicago), H.B. 671 would prohibit courts from mandating birth control use, including implantation or injection, for individuals who have committed felonies or misdemeanors. The bill advanced to the Senate, where it was assigned to committee.

TWO OTHER BILLS endorsed by ISMS remained on interim study. H.B. 1973, introduced by Rep. Ray Frias (D-Chicago), would have created the Tattoo Artists and Parlor License Act. ISMS House of Delegates policy supports state regulation and oversight, including registering with the state, submitting to inspections, conforming to sanitation standards, obtaining licenses and requiring informed consent. H.B. 1987, sponsored by Rep. David Leitch (R-Peoria), would have allowed tinted auto windows for people with illnesses or conditions forcing them to avoid direct sunlight.

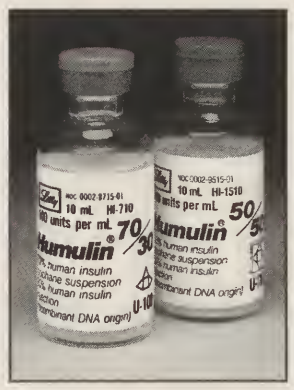
Another Leitch-sponsored bill, H.B. 683, would have amended the Medical Practice Act of 1987 to exempt certain parties from paying damages in civil lawsuits. These parties would have included physicians, corporations, hospitals and facilities that treat indigent patients by referral from a free clinic. The bill, which was placed on interim study, would have extended civil immunity coverage provided by free clinics to referred patients, as long as no fee was required. ■



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EDITORIAL

Making a difference in Springfield

Thanks to insightful legislators and your responses to calls to action, Illinois physicians and their patients won three recent legislative battles.

The Senate passed S.B. 344 – legislation capping noneconomic damage awards in civil cases, including medical malpractice, at $250,000. A cap would provide juries with a standard for measuring noneconomic losses, without imposing limits on measurable economic damages. It would prevent the inequities in awards for pain and suffering that currently exist.

The 34 senators who had the foresight to vote in favor of this legislation are listed on the wrapper of the April 23 issue of *Illinois Medicine.*

In addition, the Senate and the House failed to approve bills authorizing freestanding birthing centers. At first glance, the proposals might have seemed to simply improve access in rural areas, but they carried the potential to compromise quality of care – an unacceptable situation for doctors and patients. ISMS policy supports birthing centers only if they meet certain criteria and follow the guidelines of the American College of Obstetricians and Gynecologists, such as the requirement that these centers be attached to hospitals.

The Illinois House defeated H.B. 1459, a health care reform proposal that required a study focusing on two options and plan implementation in 1996. The proponents of the bill favor either a single-payer, tax-funded system based on the Canadian model or a heavily regulated, multi-payer system. Although the Society supports universal access to health care for all Illinoisans, we strongly opposed this legislation. The bill called for such regulations as global budgeting and expenditure caps. With global budgeting, after the funds are depleted, there can be no more spending – regardless of patients' needs. Physicians should be able to treat patients individually, not globally, according to what is in the patients' best interests. A roll call including the 57 representatives who voted against the bill is printed on page 17 of this issue.

In spite of these victories, the session is far from over. If you haven't done so already, thank your legislators who supported you by voting for S.B. 344 and against H.B. 1459. But don't stop there. Stay on top of pending legislation by reading *Illinois Medicine* and watching your mail for calls to action. Then respond by contacting your legislators, and briefly explaining your position on a specific bill and the legislation's possible effect on the health care of patients in their districts.

We *are* making a difference. Let's keep the momentum going!

PRESIDENT'S LETTER

Taking the high road in Washington



By Arthur R. Traugott, MD

I was proud to be part of the Illinois delegation attending the AMA health care summit earlier this spring. The meeting was most significant because it demonstrated that grass-roots physicians want to know what's going on in health care reform – so much so that they were willing to go to Washington to express their concern. The number of grass-roots physicians who made the trip – at their own expense – was truly overwhelming.

Even though Hillary Rodham Clinton couldn't meet with us because of her father's illness, congressional leaders readily rearranged their schedules at the last minute to talk to us about health care reform. We made our presence known in an effective and dignified way. We didn't appear to be a bunch of protesters. Consequently, leadership listened to our reasons why doctors should be included as part of the reform and agreed with us. As practitioners of medicine, we were shown the same respect by our country's leaders that society bestows on us. There was no doctor-bashing.

We made our presence known in an effective and dignified way. We didn't appear to be a bunch of protesters. Consequently, leadership listened to our reasons why doctors should be included.

As you'll recall, pre-meeting media coverage had been negative, portraying the AMA as a smug self-interest group demanding a seat on the task force. But after the meeting, coverage became positive. The media and the legislators and government officials with whom we met saw the faces of many doctors representing organized medicine instead of the faceless institution of the AMA. They saw the grass-roots doctors who care about their patients and are trying to protect the best interests of those patients. Prior to the meeting, some members had also criticized the AMA because they thought it should take a more strident stance and demand to have input into the task force. This attitude represents an understandable but continual problem for most organizations and their leaders. When information is brought to the membership, it's easy to react critically to that piece of information rather than to see the overall strategy. I believe that the entrée we received in Washington was due to our having taken the high road.

Highlights of the meeting were speeches by Vice President Al Gore, Rep. Newt Gingrich and Senate Republican Leader Bob Dole, who were especially well received by the doctors. We were all stuffed into a tiny ballroom – not comfortable quarters by any means. But once the speakers started talking, the discomfort receded. In fact, some remarks had attendees standing on their chairs and cheering.

The meeting had real impact: It showed that doctors are primarily concerned about their patients' welfare and health care reform's effects on them. That message came across loud and clear.

I came away from the meeting thrilled and proud to be a card-carrying member of the AMA and my state and county medical societies. It was apparent to everyone who attended the meeting that AMA members – individually and collectively – are concerned about patients. And the meeting demonstrated the importance of being actively involved in organized medicine.

The political commitment to health reform

The following are excerpts from speeches delivered at the AMA's March health care summit in Washington.

The administration's offer to physicians

Vice President Al Gore

I wanted to come here and speak with you directly because as our primary care givers, you must be part of any solution to this problem. One of the things that I don't like about the health care debate is that we throw around slogans and jargon, and I'm afraid we sometimes leave the impression that health care reform is some abstract notion. Just the opposite is true. This crisis hits at the heart of every American family.

•

I've learned from physicians what it is like to be trapped in a nightmare of paperwork and regulation that you had no role in designing, but that basically forces you to practice with the government looking over your shoulder. It's not right – and it's wrecking the system.

You became doctors to give care and find cures, to be among those who serve a higher purpose and feel better for it. I know that you are the backbone of our system and that many of you are anguished when talented young people choose to avoid medicine because the rewards no longer exceed the demands.

Part of our goal is to honor your original motives – great motives – by re-creating a system that allows you to practice medicine the way you thought you would when you chose your career.

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I believe that no Americans have more to gain from a complete overhaul of the medical system than doctors. You're the ones who see the scared faces of the mothers who delay seeking care for a feverish child. You're the ones who spend hours working the phones in search of permission to admit your patients or to prescribe a certain treatment. You're the ones who wonder what to do when a neighbor or friend comes for treatment and has no insurance. You're the ones for whom the status quo is unacceptable.

And so here is what we offer you: We are going to ask you to help us control skyrocketing health care costs. In return, we are going to work very hard to reform the malpractice laws and cut the bureaucracy and the paperwork that make it difficult for you to be care givers.

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In reaching these goals, rest assured that we will translate what you have told us into reality. That means malpractice reform. Today, malpractice too often lives up to its name – it has made the practice of medicine worse at the juncture where it matters most – that critical point of communication and trust between doctor and patient. We need to make certain we protect consumers too, but far too often people sue doctors even when doctors have done nothing wrong.

Reform also means relieving pressure on you. We've heard and we believe that practicing medicine had become too big a hassle. The bureaucracy has gotten too big, and the time for treatment too small. The traditional autonomy between you and your patients has given way to the new triad of medicine – a doctor, a patient and an accountant. We want to write a plan that allows you to return full time to medicine.

The big mistake of excluding 'special interests'

U.S. Senate Republican Leader Robert Dole

I can't help but think that if history turned out a little differently, I, too, might have been a member of the AMA. As a high school student in Russell, Kan., I wanted to be a doctor. I worked at a local drugstore, where the whole town seemed to pass through day after day. I have to tell you, our doctors really impressed me. I was able to see the difference that these small-town doctors made and the respect in which they were held. And it was a short step from admiring doctors to wanting to be one.

I went to college with the intention of getting a medical degree. But World War II changed that. And I spent the years after the war being a patient for doctors, instead of studying to be one.

•

The president's health care task force is in full swing, and Mrs. Clinton has some very bright policy experts working with her to help her craft a health proposal to be delivered to Congress in early May. Recently, 35 Republican senators met with the First Lady to hear her ideas and to share our thoughts and concerns about approaches to health care reform. What quickly became evident during our meeting is that Mrs. Clinton – and the president – will suffer no shortage of advice in this endeavor. Senate Republicans have been deeply immersed in the issue, too. We've had a health care task force hard at work for the past two years, and I say with pride that some of my Republican colleagues take a backseat to no one when it comes to health care expertise and compassion.

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In my view, the secrecy surrounding the drafting of the president's plan, and the exclusion of Republicans and others the White House has branded as "special interests" is a big mistake. It's bad politics; it's bad policy; it's a bad signal to be sending to all those Americans who are expecting action. The health care challenge is bigger than any one group – bigger than the White House – and the sooner we all get involved, the better.

•

I believe we all share the same goals – universal access for all in a system that contains costs while preserving choice and the high quality of care. We all want to see health care reform. We all know that we cannot sustain our current rate of spending. And we all know that we must find a way to bring everyone into the system.

•

With no relief in sight from the constant threat of costly litigation, we have to find a way to finally reform the system. In no other industrialized country do health care providers confront the day-to-day threat of litigation. It's no wonder physicians find it hard to say no when a patient demands another test, or the physician simply orders another test to avoid questions later. That's no way to do business.

That's why it's time for the Democrat majority to stand up to the trial lawyers and say, "Enough is enough!" It's also time for us to create a legal environment that encourages consolidation and coordination in the health care system, not just confrontation.

•

It's pretty easy to promise everybody everything, but that kind of propaganda will only make the crisis a permanent one.

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I can assure you that Republicans continue to be fully committed to reforming our health care system. We continue to meet on a weekly basis and will remain committed until health care costs are contained and all Americans have access to the system. We may be locked out of the White House, but we're not locked out of the debate. If the White House thinks it can go it alone – that it can exile Republicans, independents and Ross Perot supporters, that it can stiff the AMA and every other group of professionals – then it's time to tell the White House it needs a check-up.



"The doctor will see you now."

LETTERS

The real cost of heart surgery

In the March 26 issue of *Illinois Medicine* there was a graphic called "Reality vs. perception of health care costs." In reading over the list, most items seem to be correct, but one item that stands out as a glaring concern is the cost of open heart surgery. In Illinois, I believe one of the most economical programs is the Springfield program. I personally am unaware of any hospital in the nation that is currently doing open heart surgery for $7,280. I wonder where the research firm obtained its information about the cost of open heart surgery and what was included.

– Raymond A. Dieter Jr., MD
Glen Ellyn

Editor's note: The $7,280 fee listed corresponds to the physician's CPT fee code 33513, the code for four coronary venus grafts.



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Exchange expands for better service

PAGE 10

ISMIE Update

Guidelines for medical records access detailed

PAGE 11

Serving as an expert trial witness

Qualifications center on strong communication skills, credibility, thorough preparation and the ability to perform under pressure. By Rick Paszkiet

A hush falls on the courtroom. Everyone, including the plaintiff and the judge, listens carefully to the testimony of the expert witness, whose opinions may help decide the fate of the case.

This may sound like a scene from "L.A. Law," but the physician-expert witness often plays a pivotal role in a trial, providing opinions regarding standard of care and causation.

"The physician-expert witness strives to give an objective opinion based on a thorough analysis of the facts at hand," said Gerald Schwartz, MD, a gastroenterologist in suburban Chicago. "When asked to be an expert witness, I first review the case for the attorney and give a professional assessment of what occurred. If my opinion is favorable to the attorney's case, I become an expert witness and help the attorney present the case's relevant points."

One prerequisite is good communication skills. "Expert witnesses have to know how to communicate without appearing too slick in their presentation," said Mike Wagner, a Chicago attorney with Baker & McKenzie. "They should be teachers, not lecturers. I'm looking for experts who are politely assertive, not argumentative or defensive."

> *Physician-expert witnesses should have a mix of hands-on, clinical experience and a solid academic background.*

Perhaps the most crucial qualification is credibility. According to Wagner, physician-expert witnesses should have a mix of hands-on, clinical experience and a solid academic background.

Experience as an expert witness isn't always a plus. "I avoid using physicians who have extensive experience as expert witnesses – they may give the impression of being hired guns," said Scott Spooner, a Springfield attorney with Heyl, Royster, Voelker & Allen. "I have had success with physicians who are actively practicing their specialty, preferably from a teaching hospital. It's also essential that they be board certified."

TYPICALLY, THE ATTORNEY presents the physician with a detailed record of the case, and if the physician's conclusion is favorable to the attorney's client, the physician is asked to serve as an expert witness.

In Illinois, as long as expert witnesses are familiar with the facts under discussion and have a current and unrestricted license, the trial judge may permit them to testify – even if the physicians are neither actively involved nor board certified in a particular specialty.

Nevertheless, ISMS policy states that expert witnesses should be physicians licensed to practice medicine in all its branches, and have basic educational and professional knowledge as a foundation for testimony. They must also possess special expertise, relevant personal experience, practical familiarity and technical knowledge of the problems being considered. In addition, they should understand alternative forms of treatment.

PHYSICIANS' ABILITY to perform under trial pressure is as important as their curricula vitae. The weight placed on expert testimony creates some of that pressure. "In a complicated medical case, you are at the mercy of the expert witness," said Spooner. "Medicine has become so exotic that the jury sometimes can't use its common sense to weigh a case. Cases often become beauty contests between expert witnesses."

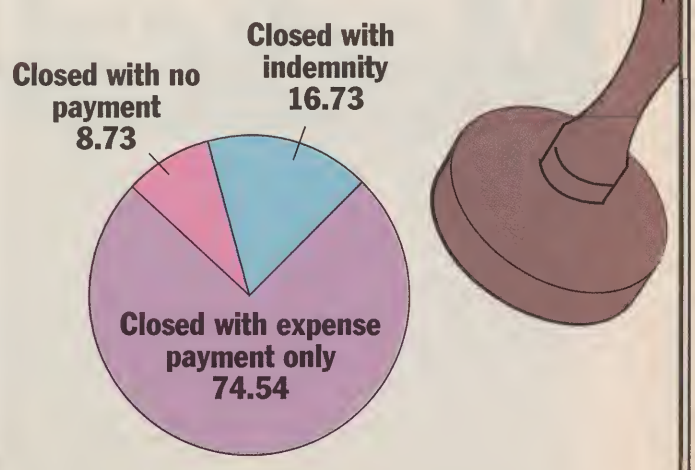
Cross-examination, too, imposes pressure. "A cross-examination can be tough, but contrary to what most people think, I don't spend much time coaching the expert witness," said Spooner. "You're alerting the witness to the probable area of inquiry. I emphasize that circumspection is a virtue; this is not a conversation, so [experts should] try to just answer the plaintiff's attorney's questions."

Expert witnesses are most effective when they are familiar with the material, according to Dr. Schwartz. "That's what keeps you comfortable," he said. "You have to anticipate what will be addressed. What is the plaintiff's attorney going to bring up? This requires preparation. Sometimes I'll spend more than 20 hours of preparation for only one morning of testimony."

In fact, time constraints are cited by physicians and attorneys alike as the most frustrating part of serving as an expert

(Continued on page 10)

Percentage of ISMIE closed claims 1985-92*



*Eighty-three percent of ISMIE closed claims are closed with no damages paid on behalf of the policyholder.

Source: Illinois State Medical Inter-Insurance Exchange

MALPRACTICE ROUNDUP

Surgeon must warn in case of transfusion

A Pennsylvania federal district court ruling increases the scope of surgery-associated risk that must be disclosed. The court ruled that if a surgical procedure may necessitate a blood transfusion, physicians must inform patients about transfusion risks to obtain complete informed consent.

As reported in *Medical Malpractice Law & Strategy*, a plaintiff claimed he received HIV-contaminated blood during surgery performed by one of the defendants. He alleged that the surgeon failed to inform him of the alternatives to a transfusion and of the risks. The defendants moved to dismiss, claiming there was no duty to obtain informed consent for a transfusion.

Pennsylvania limits the doctrine of informed consent to cases involving surgical procedures, because the doctrine is grounded in the tort of battery. In a prior case, a Pennsylvania appellate court refused to expand the doctrine to include the administration of therapeutic drugs when a patient has not been told about potential side effects. The court in the transfusion case allowed the use of the informed consent doctrine. In this case, unlike in drug administration situations, the plaintiff agreed to surgery, which included the possibility of a blood transfusion. The court deemed the transfusion to be part of surgery, not a separate event. ■

Health care worker HIV policy introduced

As reported in *Medical Liability Monitor*, Lexington Insurance Company in Boston now offers coverage for health professionals who contract HIV. Covered employees of a hospital, health facility or laboratory who are diagnosed with HIV receive a lump sum payment of $500,000. The plan can stand alone or be handled as an endorsement to a facility's professional liability policy. Coverage does not require the employee to have contracted the virus on the job.

Physicians' Benefits Trust, an insurance company covering ISMS members, is developing a similar policy slated for July 1 implementation. ■

Exchange expands for better service

SERVICE: Continuing its Physician-First Service program, the Exchange opens new regional offices in Belleville and Rockford. By Gina Kimmey

[CHICAGO] In April 1991, the Exchange renewed its commitment to provide exceptional service to its policyholders by implementing the Physician-First Service initiative. Two years into the program, that commitment builds on the success achieved in the Chicago and Springfield offices, with the opening of offices in Belleville and Rockford.

"Our Physician-First Service policy calls on us to better serve policyholders throughout Illinois by making a good company even better," said Harold L. Jensen, MD, chairman of the Exchange Board of Governors. "Exchange insureds practice in all corners of the state. The Exchange, as a statewide physician-owned company, should give personal service to all policyholders."

The concept of regional offices was first tested with a satellite office in Springfield, opened 4½ years ago. After that office's success and the implementation of Physician-First Service, the Exchange decided to extend the closer service to other communities.

Each regional office will be staffed by at least two Exchange professional liability analysts and one underwriter. The Belleville office, opened April 26, is supervised by the Springfield office; the Rockford site, slated to open June 1, will report to the Chicago office. The claims and underwriting staff, who are familiar with the communities, will be able to offer more convenient service to policyholders in those areas of Illinois, he said.

"Regional offices allow us to reach out to our policyholders and bring the company to them. The main thrust in Chicago and the satellite offices is service and convenience to the policyholder," he noted. "The success of the Exchange is rooted in our commitment to meeting all the needs of our physician insureds. The purpose of the service initiative is to make malpractice protection as painless and hassle-free as possible.

Exchange regional offices



*The Rockford office is scheduled to open June 1.

"The policyholders own the Exchange, and we will treat them like owners," continued Dr. Jensen. "We will take every step we can to ensure that our policyholders are satisfied with their company."

The Belleville office can be reached at (618) 236-5890. A number for the Rockford office will be available soon. ■

Expert witness

(Continued from page 9)

witness. For the attorney, the most qualified physician may also be the busiest and least accessible; for the physician, the preparation time and the frequent trial delays can interfere with practice or research demands.

Despite the pressure and time constraints, serving as an expert witness offers rewards: the opportunity to share knowledge, exchange ideas, defend the medical profession and, of course, discover the truth.

"In the end, the first principle that guides the expert witness is a commitment to the truth," said Spooner. "The expert witness illuminates the true facts of the case without being partisan. This is a valuable service to the medical profession."

For information on becoming an expert witness for the defense, physicians may contact the Exchange at (312) 782-1654 or (800) 782-ISMS. In addition, the risk management department offers on loan a videotape and pamphlet that help physicians prepare to be expert witnesses. Interested physicians may call (312) 782-2749. ■

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Guidelines for medical record access detailed

MEDICAL LEGAL GUIDELINES

Physicians are required to provide patient medical records on a patient's behalf to an attorney or another physician, according to Illinois law [735 ILCS 5/8-2003 (1992)], formerly [Ill. Rev. Stat., ch. 110, par. 8-2003]. Physicians may either provide copies or allow the attorney or physician to examine the original records. There are no legal requirements mandating that physicians must give medical records to patients. However, physicians must comply with patient-authorized requests for medical records to be given to a physician or attorney within 60 days. Physicians may not withhold medical records because a patient failed to pay for services, but may charge a reasonable fee for copying the medical records. The statute implies that prepayment for copying fees is acceptable, and many physicians do require prepayment.

ISMS policy states: "In the case of nonhospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies."

However, from a risk-management standpoint, physicians should consider the implications to the physician-patient relationship by refusing to provide the records. Specifically, physicians are advised to make the records available so that patients do not have to hire an attorney to get them, unless there are extenuating circumstances, such as a patient's mental illness.

This advice for medical records access does not apply under certain conditions. Patient or guardian consent must be given for access by third parties (except under specific circumstances), a PRO, Industrial Commission personnel and patients' attorneys in Worker's Compensation cases, certain other government agencies, and child abuse investigators.

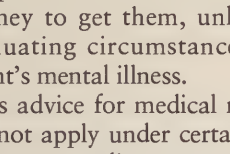
HOSPITALS MUST ALLOW a patient, patient's physician or patient's attorney to inspect and copy patient records after the patient has been discharged, according to Illinois law [735 ILCS 5/8-2001 (1992)], formerly [Ill. Rev. Stat., ch. 110, par. 8-2001]. Written requests for patient records must be given to hospital administrators and must be honored within 60 days of receipt.

NURSING HOME PATIENTS and their legal guardians – or if they are minors, their guardians or parents – must be allowed to copy and inspect records kept by the facility or the physician, according to state law [210 ILCS 45/2-104(d) (1992)], formerly [Ill. Rev. Stat., ch. 111 1/2, par. 4152-104(d)]. Nursing homes may charge a fee for copying the records, the law states. Specific requirements for the content, form, retention and transfer of patient records are included in IDPH rules (77 Ill. Adm. Code 300.1810-300.1880).

COMMUNICABLE DISEASES must be reported to IDPH by physicians, as mandated by state law [410 ILCS 315/0.01 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 111 1/2, par. 22.11 et seq.], and (77 Ill. Adm. Code 690). IDPH considers such records confidential and nondiscoverable, as detailed in Illinois law [745 ILCS 45/0.01 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 126, par. 21]. The Illinois Supreme Court accepted this interpretation in the context of state's attorney's requests for sexually transmitted disease reports for use in grand jury proceedings in its ruling in *People vs. Calvo* (1982), 59 Ill. Dec. 639, 89 Ill. 2d 130, 432 N.E. 2d 223.

For specific guidelines, see the ISMS brochure "A Physician's Guide to Medical Record Access and Retention." ■

Editor's note: This is part of a series on medical-legal issues written by the ISMS Medical Legal Council. These guidelines do not necessarily represent ISMS policy. They address legal concerns that physicians commonly express to ISMS and are intended to serve as only a guide for physicians, not specific legal advice.



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REHABILITATION MEDICINE

Orchestrating the players in rehabilitation

Physicians conduct a team of physical and speech therapists, social workers, family members and the patient to achieve the best results.

BY RICK PASZKIET



Jim McNally

Whether it's a patient who has experienced a stroke or one with a sports injury, the goal of physicians in rehabilitation medicine is the same: to help the patient function at maximum capacity again. Achieving this goal requires intense commitment from the physician, the rehab therapists, the patient and the patient's family.

"By its very definition, rehab medicine is a collaborative effort on the part of medical specialists to bring physically disabled people up to their maximum functional abilities," said Henry B. Betts, MD, medical director and CEO of the Rehabilitation Institute of Chicago. "In rehab medicine, you're reintegrating the patient into community life by taking into account all the issues that contribute to a high quality of life."

Adding to this challenge is rehab medicine's relative youth: It is just moving out of its infancy. Although rehab medicine has existed since water therapy was used by the ancient Romans to soothe chronic pain, it was established as a medical specialty only in the late 1940s and has received scant attention until the past few years.

You have to move away from the authoritative model in which you're saying to the patient, 'Do this. Do that.' The rehab process is much slower and requires the primary care giver to assume a leadership role among the therapists, nurses and other attending physicians.

"WHEN I FIRST started in rehab medicine, it was seen as a decidedly small pea in the pot," said Thomas E. Szymke, MD, executive director of the Institute for Physical Medicine and Rehabilitation in Peoria. "But now it has a much more visible presence because it can help fix the patient's problem and get him or her back home and working again. This is especially important given the spiraling costs of nursing home care.

"Years ago, it was difficult for physicians to 'think rehabilitation' for their patients," Dr. Szymke continued. "But the federal government, through the incentives of its reimbursement system, has played a key role in establishing a rehab mind-set. Today, hospitals in Illinois and across the country are striving to get patients out of acute care and into a rehab program. It makes economic sense."

It also makes sense for the rehab patient. "The framework in which a physician normally views a patient is altered in rehab medicine," said Marc E. Duerden, MD, senior resident at the Rehab Institute. "You have to move away from the authoritative model in which you're saying to the patient, 'Do this. Do that.' The rehab process is much slower and requires the primary care giver to assume a leadership role among the therapists, nurses and other attending physicians."

IN A SENSE, the primary physician is a symphony conductor carefully orchestrating the movements of the other players – the physical and speech therapists, rehab nurses, social workers, family members and, of course, the patient. All members of the symphony are working toward the same goal: helping the patient function as well as possible. But it's the physician who must direct this sometimes complicated process, a point supported by ISMS policy.

To effectively supervise the process, the physician must have excellent communication skills. "Not only do you have to communicate effectively with the patient, but you're also dealing with teams – sometimes huge ones," Dr. Duerden said, "and all the members have to know the established goals and the progress that has been made."

THE REHAB PROCESS usually follows a typical format depending on the setting. After a patient is admitted to a rehab program, the primary care giver and rehab team complete an initial assessment to evaluate the patient's condition and establish short- and long-term goals, according to Dr. Szymke. The team then develops strategies and creates a rehab plan. To evaluate the patient's progress and condition, team conferences are held, usually every two weeks.

"You monitor patient care through 'functional independent matters,' such as mobility, strength and perceptual motor skills," said Dr. Szymke. "The rehab team takes all these FIMs into account when setting a patient's goals."

The most important players are the patient's family members. "Rehab medicine can't work without a buy-in from the patient and his or her family," said Dr. Betts. "In fact, family members are the foundation of a patient's recovery."

The family, like the patient, must go through an extensive educational process. "The family has to learn the necessary skills to take care of the patient,

(Continued on next page)

Taking a walk down 'Easy Street'

After a debilitating illness or injury, patients face the daunting challenge of relearning basic activities and functions. This goal has been facilitated by Aurora's Copley Memorial Hospital, which added "Easy Street" to its RehabCare Unit this year. With "Easy Street," Copley has simulated real-life situations encountered by every rehab patient.

"This new facility is a tremendous benefit to people who are disabled from accidents, strokes, spinal cord injuries, amputations or orthopedic problems," said Phyllis Lloyd, executive director of the Copley Healthcare Foundation. "Patients will have hands-on experience in our simulated community setting, which makes their transition from the hospital environment back to the 'real world' much easier."

Patients learn how to deal with heavy doors, narrow walkways and different types of floor coverings, as well as activities that are a part of daily life. "Easy Street" is equipped with a grocery store, a car, a garden cafe, laundry facilities and even an automatic teller machine simulator.

According to Lloyd, cognitive skills are integrated into the "Easy Street" therapy program. Patients' progress can be evaluated on their proficiency in counting change, reading labels and menus, and balancing a checkbook.

Taking a walk on "Easy Street" also gives patients a feeling of independence. As they accomplish more everyday tasks, their confidence builds, allowing them to progress as far as possible.

– Rick Paszkiet

Rehabilitation

(Continued from page 13)

as well as make any necessary modifications to the home environment," said Dr. Szymke.

ANOTHER FACTOR AIDING the rehab process is technology. "There are wonderful opportunities for patients, because of new technology," said Dr. Betts. "The advances in miniaturization and bioengineering are incredible."

Prostheses have also been significantly improved and are now made from advanced carbon fiber, which is stronger than steel. Even wheelchairs are being made lighter and stronger.

"Not all of these technologies are necessarily expensive," said Dr. Szymke. "For instance, your basic video game is a tremendous aid for a left-neglect stroke patient to improve his or her cognitive programs. Such therapies weren't available 15 years ago."

Still, the greatest advance in rehab medicine may simply be awareness. "Society no longer rejects the disabled," said Dr. Betts. "We are more attuned to helping rehab patients, and we have a better understanding of their needs and the contributions they can make to the community." ■

Health measures

(Continued from page 4)

would have deleted language in the AIDS Confidentiality Act allowing health care providers to notify the parents of a minor who tests HIV-positive.

Legislation that would limit work hours for residents to 80 hours per week was defeated in Senate and House committees. ISMS opposed S.B. 378, sponsored by Sen. Miguel del Valle (D-Chicago), and an identical House bill, H.B. 792, sponsored by Rep. Jan Schakowsky (D-Evanston).

The bills proposed to limit work hours for residents in all specialties, regardless of guidelines set by the Accreditation Council for Graduate Medical Education calling for each residency program to establish its own formal policy on work hours. Any hospital failing to comply with the bills' provisions would have been subject to license suspension or revocation.

Physicians who provide care to indigent patients without charge would have received tax relief under H.B. 475, sponsored by Rep. Donne Trotter (D-Chicago). The bill, which did not advance, would have recognized pro bono care by reducing physicians' taxable income by $50 an hour and $100 an hour after 50 hours. ISMS was studying the bill. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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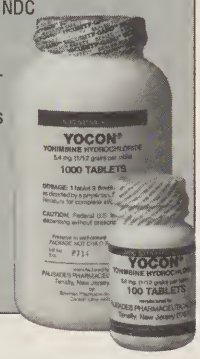
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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H.B. 1459 dies in Illinois House of Representatives

The Illinois House of Representatives failed to advance H.B. 1459 – a health care reform proposal calling for the creation of a bipartisan commission to study and implement a single-payer, tax-funded system based on the Canadian model or a heavily regulated, multi-payer system. ISMS previously issued a call to action urging members to contact their legislators and explain why patients would not benefit under the proposed legislation.

The Society encourages members to thank those legislators who voted to defeat this bill. The roll call is printed below.

Ackerman (R-Morton)	N	Granberg (D-Centralia)	N	Moore, A. (R-Libertyville)	N
Balanoff (D-Chicago)	Y	Hannig (D-Gillespie)	Y	Moore, E. (D-Maywood)	Y
Balthis (R-Lansing)	Y	Hartke (D-Effingham)	Y	Morrow (D-Chicago)	Y
Biggert (R-Westmont)	N	Hassert (R-Lemont)	N	Moseley (D-Springfield)	Y
Biggins (R-Elmhurst)	N	Hawkins (D-Murphysboro)	Y	Mulligan (R-Des Plaines)	N
Black (R-Danville)	N	Hicks (D-Mt. Vernon)	N	Murphy, H. (D-Markham)	P
Blagojevich (D-Chicago)	Y	Hoeft (R-Elgin)	N	Murphy, M. (R-Oak Lawn)	N
Brady (R-Bloomington)	N	Hoffman (D-Collinsville)	Y	Noland (R-Decatur)	N
Brunsvold (D-Rock Island)	Y	Homer (D-Canton)	Y	Novak (D-Kankakee)	N
Bugielski (D-Chicago)	Y	Hughes (R-McHenry)	N	Olson (R-Lincoln)	N
Burke (D-Chicago)	Y	Johnson, Tim (R-Urbana)	N	Ostenburg (D-Park Forest)	Y
Capparelli (D-Chicago)	Y	Johnson, Tom		Pankau (R-Roselle)	N
Churchill (R-Antioch)	N	(R-West Chicago)	N	Parcells (R-Glenview)	N
Clayton (R-Buffalo Grove)	N	Jones, L. (D-Chicago)	Y	Parke (R-Schaumburg)	N
Cowlishaw (R-Naperville)	N	Jones, S. (D-Chicago)	Y	Pedersen (R-Palatine)	Exc
Cross (R-Yorkville)	N	Kaszak (D-Chicago)	Y	Persico (R-Glen Ellyn)	N
Curran (D-Springfield)	Y	Kotlarz (D-Chicago)	Y	Phelan (D-Chicago)	Y
Currie (D-Chicago)	Y	Krause (R-Mt. Prospect)	N	Phelps (D-Eldorado)	Y
Daniels (R-Addison)	N	Kubik (R-Riverside)	N	Prussing (D-Champaign)	Y
Dart (D-Chicago)	Y	Lang (D-Skokie)	Y	Pugh (D-Chicago)	Y
Davis (D-Chicago)	Y	Laurino (D-Chicago)	Y	Ronen (D-Chicago)	Y
Deering (D-Nashville)	Y	Lawfer (R-Freeport)	N	Roskam (R-Wheaton)	N
DeJaegher (D-East Moline)	Y	LeFlore (D-Chicago)	Exc	Rotello (D-Rockford)	N
Deuchler (R-Aurora)	N	Leitch (R-Peoria)	N	Rutherford (R-Pontiac)	N
Dunn (D-Decatur)	Y	Levin (D-Chicago)	Y	Ryder (R-Jerseyville)	N
Edley (D-Macomb)	Y	Lindner (R-West Dundee)	N	Saltsman (D-Peoria)	Y
Erwin (D-Chicago)	N	Lopez (D-Chicago)	Y	Salvi (R-Wauconda)	N
Flinn (D-Granite City)	Y	Martinez (D-Chicago)	Y	Santiago (D-Chicago)	Y
Flowers (D-Chicago)	Y	Mautino (D-Spring Valley)	N	Saviano (R-River Grove)	Y
Frederick (R-Lake Forest)	N	McAfee (D-Summit)	N	Schakowsky (D-Evanston)	Y
Frias (D-Chicago)	Y	McAuliffe (R-Chicago)	N	Schoenberg (D-Wilmette)	N
Gash (D-Deerfield)	N	McGuire (D-Joliet)	Y	Sheehy (D-Tinley Park)	Y
Giglio (D-Calumet City)	Y	McPike (D-Alton)	N	Skinner (R-Crystal Lake)	P
Giolitto (D-Belvidere)	Y	Meyer (R-Bolingbrook)	N	Steczo (D-Oak Forest)	Y
Giorgi (D-Rockford)	Y	Moffitt (R-Monmouth)	N	Stephens (R-O'Fallon)	N
Stroger (D-Chicago)	Y	Weller (R-Morris)	N	Speaker Madigan	
Tenhouse (R-Quincy)	N	Wennlund (R-New Lenox)	N	(D-Chicago)	Y
Turner (D-Chicago)	Y	Wirsing (R-DeKalb)	N		
Von Bergen		Wojcik (R-Schaumburg)	N	Yeas	57
Wessles (D-Sterling)	Y	Woolard (D-Marion)	Y	Nays	57
Walsh (R-Westchester)	N	Younge (D-East St. Louis)	Y	Present	2
Weaver (R-Mattoon)	N	Zickus (R-Palos Hills)	N	Exc/not voting	2

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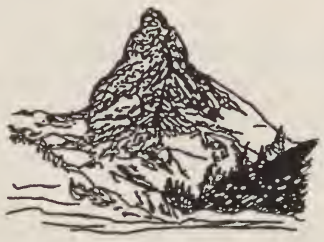


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Rural health measures

(Continued from page 1)

bill that was signed into law. The bill would fund IDPH grants for various programs, including matching grants to community-based organizations for comprehensive primary care and to hospitals for service diversification. The second part of the bill focuses on funding for projects created by Southern Illinois University and the University of Illinois College of Medicine at Rockford. In total, the bill requests $1.65 million for rural health care access programs. ISMS testified in support of H.B. 1693, which had the additional support of Rep. Tom Ryder (R-Jerseyville).

"This is a key piece of legislation on which we are working closely with the Illinois Rural Health Association for passage," said George T. Mitchell, MD, co-chairman of the ISMS Committee on Health Care Access. Dr. Mitchell praised the U of I Rural Medical Education Program, which would reserve medical school slots for students from rural counties who promise to return to rural communities to practice after graduation.

George O'Neill, president of the Rural Health Association, also lauded the Rockford program, but said that none of the three parts of the bill would generate a solution to the shortage of care in rural areas. "Each part deals with a different aspect of access. No one knows which will work better. We know that [the legislation] will make an impact." O'Neill explained that the bill was developed over five years by a coalition of health care advocates and legislators.

Another access bill, H.B. 32, would create the Healthy Kids Plan Act. Introduced by Rep. John Dunn (D-Decatur), the measure would allow voluntary enrollment in a plan to provide health care services to children who are not eligible for public aid and are not otherwise insured but meet low-income eligibility requirements. ISMS is studying the plan, which would be funded by the state and sliding scale fees. Inpatient hospital stays would not be included in the plan.

A third legislative effort would generate discussion on the impact of shortages of family physicians in rural areas. Senate Joint Resolution 12, sponsored by Howard Carroll (D-Chicago), would create the Special Task Force on Family Physician Shortages to recommend ways to increase funding for family practice residency training programs, increase the number of family physicians graduating from Illinois medical schools and provide incentives for family physicians to practice in underserved areas.

ISMS is suggesting an amendment to SJR 12 to expand the legislation so that it includes all primary care physicians in addition to family physicians.

Although ISMS House of Delegates policy supports expanded access to care in rural areas, quality of care is also a high priority. The April 24 defeat of a bill that would have authorized birthing centers as alternative health care models is a partial success for physicians committed to patient safety. S.B. 228, sponsored by Sen. Karen Hasara (R-Springfield), lost on third reading on the Senate floor. Consideration of its House counterpart, H.B. 552, sponsored by Phelps, was postponed. ISMS policy supports the creation of model birthing centers only if they meet certain criteria and adhere to American College of Obstetricians and Gynecologists guidelines.

"We're taking a grass-roots approach [to expanded access], but we need governmental support," Dr. Mitchell said, adding that ISMS is working with underserved communities through such programs as the Society's rural health speakers bureau.

Dr. Mitchell also emphasized the importance of passing legislation that would place a $250,000 cap on noneconomic damages in tort suits. He noted that physicians often shy away from rural practices because of the high cost of malpractice insurance. "We have a lot of things working right now to expand access, but it's going to take time." ■

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*Table refers to 3-oz, cooked servings.

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- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
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1. US Dept of Agriculture. *Composition of Foods: Pork Products,* 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products,* 1979. Agricultural handbook 8-5.

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Pharmaceuticals

(Continued from page 3)

and graphs analyzing percentages of GNP in Europe and here in the U.S. I just want to know the facts. Where is the money going?"

Dr. Orlowski did acknowledge that significant time and money are expended bringing new drugs to market, but she challenged drug companies to look at their profits and "make sure they are modest." She stressed that the industry should play a more prominent role in educating the public about how drug prices are set and explaining the beneficial free drug programs many companies administer. "[If they] bring the numbers to a point where they are easily understood, they could find their image improving," she added.

Dr. Scheibling, however, believes there is little drug companies can do to resolve their image problem. Given the Clinton administration's comments about reining in drug costs, "there isn't really anything [pharmaceutical companies] can do at this point. Eventually the government will tell them what to do, and they are going to have to do it. They don't have much of a choice." ■

Reform task force

(Continued from page 1)

Access Committee said an acceptable plan must include services that reflect the ever-changing needs of a growing population. Committee Chairman Susan Manilow, chairman of the Mt. Sinai Hospital Medical Center Board of Trustees, said the committee will recommend a system by which facilities, professionals and services are distributed to "allow timely care within a reasonable distance." She noted that the costs of financing such a system should be equitably distributed among government, employers and individuals.

The Finance Committee will focus on finding effective ways to use financial resources within Illinois' current health care system, said Vince Kelly, committee chairman and vice president for health care finance at First National Bank of Chicago. The committee has three primary areas of responsibility – developing and initiating long-term strategies for controlling rising health costs, analyzing the financial impact of all health care reform initiatives submitted, and evaluating health care reform measures proposed by the federal government and assessing their economic impact on Illinois health care.

Working to improve quality, access and cost-effectiveness in health care delivery, the Managed Care Committee will recommend ways to integrate the different payers into health delivery system reforms, said Lee Domanico, committee chairman and CEO of Columbus-Cabrini Medical Center. Domanico said the group will coordinate its activities with the Access and Finance committees.

THE GOVERNOR'S TASK FORCE also received a briefing on the status of national health care reform. Kate Sullivan, associate director of the governor's Washington office, reported that although the Clinton administration continues stressing its intention to forward a plan to Congress for passage this year, key legislators in the U.S. House and Senate do not believe this is possible, Sullivan said.

Sullivan updated the group on possible key elements of the new system, including computerized "smart cards" for all Americans, detailing patients' medical histories. The plan could be based on a system of employer-mandated coverage with federal subsidies available for smaller businesses, she said.

"Details of the basic benefits package have yet to be specified, but mental health and substance abuse coverage [may] be included. Costs will ultimately determine how comprehensive the package will be," said Sullivan.

WHETHER THROUGH purchasing cooperatives determined by the state or through self-insured entities, community rating practices will likely be used by insurers, Sullivan said. "The effect on the current insurance industry may be substantial," Sullivan said. "Reform [could] favor larger insurers and those that are effective 'care managers.' Smaller companies may simply not be profitable."

Sullivan conjectured that Medicaid could cease to exist as a separate program. States will also probably still be responsible, at least in part, for the costs of long-term care "until that system reaches a crisis and a major federal solution is required," she said.

Illinois has been involved in the federal reform process through the National Governors Association. "Eight or nine states are working closely with the White House task force," said Felicia Norwood, the governor's executive assistant for human services. "The down side is that all of the states, with the exception of Texas, are relatively small states and don't have the same problems as larger states like Illinois."

The full task force will most likely not meet again until sometime in the fall, Wish said. In the meantime, the subcommittees will continue working and preparing their recommendations for a viable, affordable health care reform plan for Illinois, he said. ■

H.B. 1459

(Continued from page 1)

regulated by government bureaucrats, Dr. Traugott said. "Physicians would have been underrepresented on the study commission called for in the bill. The result would have been the heavy hand of government intruding on the practice of medicine."

Dr. Traugott also lauded the efforts of Illinois physicians for joining the battle to kill this legislation. Responding to an ISMS call to action about the bill, physicians from around the state contacted legislators to explain why patients would not benefit under Edley's proposal.

"With the legislative session in full swing, physicians must continue participating in the political arena," Dr. Traugott noted. "Many health-care-related measures are still pending before the General Assembly, some advantageous to the profession and others posing dire consequences for patient care. Caps on noneconomic damage awards and expanded functions for allied health professionals are but a few of the issues in which organized medicine has a vested interest on behalf of our patients. Don't let Illinois lawmakers act on health legislation without your input."

To see how your representative voted, check the roll call on page 17. ■

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Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General.**)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, anó, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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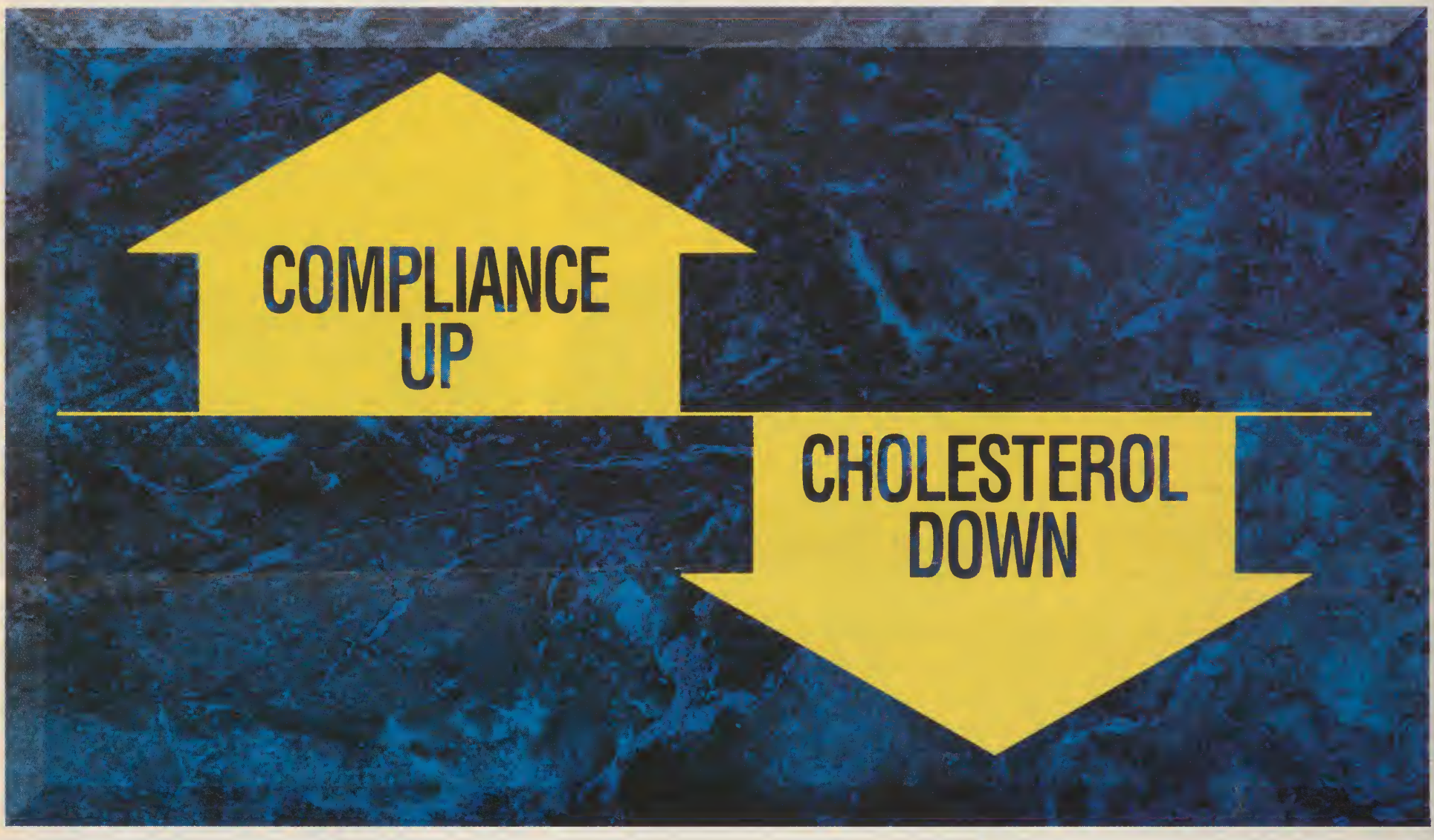
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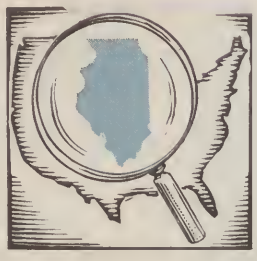
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HISTO N PROBLEM PREGNANCIES (PAGE 10)

Illinois Medicine

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More bill coverage

PAGE 3

Practicing without a license jeopardizes liability coverage

PAGE 9

Illinois House dims hope for caps this year

DEFEAT: Caps bill dies in House committee after surviving half of the spring legislative season. By Anna Brown

[SPRINGFIELD] After considerable parliamentary maneuvering, a bill that would have capped noneconomic tort awards, including malpractice awards, came to a halt in House committee May 4. The death of S.B. 344 makes the chances for passing meaningful tort reform this year very slim.

ISMS President Arthur R. Traugott, MD, who testified before the House Judiciary I Committee in support of S.B. 344, said he was "extremely disappointed" about the bill's failure. Sponsored in the House by Rep. Anne Zickus (R-Palos Hills) and in the Senate by Sen. Thomas McCracken Jr. (R-Westmont), the bill would have placed a $250,000 cap on noneconomic malpractice damage awards.



Ron Ackerman

Dr. Traugott testifies before a House committee on S.B. 344.

The defeat was especially dis-

(Continued on page 21)

Anti-smoking campaign targets women

PSAs: Illinois is borrowing an education campaign to curb women from smoking. By Tamara Strom

[SPRINGFIELD] "You've come a long way, baby" is one of the most successful – and most ironic – cigarette advertising campaigns ever launched by the tobacco industry. To combat the tide of women smokers and fight back at cigarette makers, Illinois Lt. Gov. Bob Kustra unveiled two television public service announcements slated to air statewide. The campaign is being conducted in cooperation with the Illinois Department of Public Health.

"We must challenge tobacco advertising that tries to per-

(Continued on page 22)

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OSHA compliance scam surfaces

PAGE 2

Society leadership takes office

PAGE 4

Tending to patients' needs

A profile of the new ISMS president

PAGE 12

DEPARTMENTS

News Briefs.....2

Commentary.....6

Letters.....7

ISMIE Update.....9

Classifieds.....19



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THREE GENERATIONS of ISMS leadership – President-elect Alan M. Roman, MD; President Arthur R. Traugott, MD; and Immediate Past President Arvind K. Goyal, MD – review resolutions during the Annual Meeting.

Delegates debate reform, other issues at Annual Meeting

PHYSICIAN ACTION: The unsettled state of health care makes its mark as the ISMS House of Delegates adopts new policies. By Anna Brown, Gina Kimmey, Lynn Koslowsky and Tamara Strom

ANNUAL MEETING 1993

[OAK BROOK] By adopting in principle a framework for building a detailed health care reform package for Illinois, the ISMS House of Delegates completed business for another year when it adjourned its annual meeting in Oak Brook April 25. During the three-day meeting, delegates acted on 86 resolutions, tackling such timely issues as economic credentialing, rural access to health care, utilization review regulation and physician billing practices, in addition to health care reform.

The House of Delegates adopted with no significant change a working reform strategy developed by an ISMS ad hoc committee chaired by new ISMS President Arthur R. Traugott, MD. Under the proposal, every Illinois resident would be guaranteed at least a basic package of health care services. The approach to health reform was adopted and referred to the ISMS Board of Trustees for further scrutiny and refinement. Details of the final plan will depend on input from specialty societies, businesses, government, patients, hospitals and other health care providers, as well as on changes in federal ERISA laws governing self-insured health plans.

"No single group can decide the specifics needed to reform our health care system," said Dr. Traugott. "We must have input from all parties involved in order for a health care reform plan to work and be accepted by everyone."

The House also adopted a revised version of the Society's Health Care Reform Principles, originally approved last year. The updated principles conform with the new reform strategy.

(Continued on page 17)

ISMS PERSPECTIVE

THE TROUBLE WITH H.B. 2048

The Illinois House of Representatives recently defeated H.B. 2048. As originally introduced, the bill would have authorized certified nurse midwives and certified nurse practitioners to receive 100-percent direct reimbursement for the same procedures and visits as those provided by physicians. (It was amended to exclude nurse midwives and to reduce the payment amount to 90 percent.) Basically, H.B. 2048 would have allowed the Illinois Department of Public Aid to designate nurse practitioners as primary care providers to children and pregnant women eligible for medical assistance. The bill received 58 of the 60 votes needed for passage.

Although this bill may be dormant for now, the issue behind it will undoubtedly resurface. In fact, the issue was the subject of debate at the recent 1993 ISMS Annual Meeting, with some physicians expressing a lack of understanding of ISMS policy.

H.B. 2048 conflicts with ISMS policy because it states that patients should receive appropriate care under the direction and

(Continued on page 23)

OSHA compliance scam surfaces

CME: Physicians have received information about completing a phony OSHA requirement.
By Anna Brown

[CHICAGO] When attempting to comply with OSHA's new bloodborne pathogens rules, physicians should watch for misinformation being circulated in Illinois about a phony CME program, according to ISMS officials. ISMS and the AMA obtained copies of a brochure offering three hours of category I AMA/PRA CME credit for completing a quiz supplied by a company called Legal Economics Guidelines. The company claims the self-study program and quiz, which cost $40, will satisfy OSHA's "mandatory annual education requirements." The OSHA guidelines contain no such educational mandates.

The Florida-based company mails its packet, "1993 Physician Update: Bloodborne Pathogens: Exposure and Risk Reduction based on OSHA Bloodborne Pathogen Standard," free to physicians. But doctors will not receive the CME credits offered without paying the $40 fee. The phrase "mandatory education requirement" appears throughout the material.

"The information is definitely inaccurate," said Michael J. Zarski, AMA legal counsel. "The AMA has complained to OSHA, which has referred problems to the Federal Trade Commission." According to Zarski, OSHA officials are frustrated by such scams and similar attempts by cottage industries to peddle compliance kits at highly inflated prices. An article appeared in the March 22/29 issue of *American Medical News* warning physicians about groups that often use scare tactics to offer phony or overpriced compliance materials.

Only physicians' employees who come in contact with bloodborne pathogens must be trained annually to meet the OSHA standard, Zarski said. "Training requirements are laid out in OSHA guidelines, and the trainer doesn't have to be a certified instructor. He or she can be a physician employer."

Zarski suggested that physicians take advantage of training materials offered by the AMA and other medical societies. The Chicago Medical Society also offers a program for physicians, he said.

"[Groups] calling themselves consultants exploit peoples' fears of OSHA, even in areas other than medicine," Zarski said. When physicians subscribe to such programs, they stand to lose a lot of money.

ISMS policy states that the Society "should have a primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities." In addition, "sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation of procedures of offered courses."

For more information about OSHA compliance, contact the ISMS medical services department at (312) 782-1654 or (800) 782-ISMS. ■

IDPH penalizes abusive WIC program vendors

[SPRINGFIELD] After sleuthing to uncover abuses in the Women, Infants and Children program, the Illinois Department of Public Health has fined and terminated 30 Chicago-area vendors participating in WIC.

Vendors suspected of fraud were tracked through IDPH's new computer system, which shows redemption patterns of WIC "food instruments" – vouchers that allow participants to obtain nutritious food items, explained Tom Schafer, IDPH spokesperson.

"The new computer system allows us to track irregularities in redemption patterns of food instruments. We targeted vendors that showed irregularities and contracted with a private firm to make undercover buys of WIC food items."

Vendors who were terminated either charged IDPH for WIC food not received by participants or overcharged for WIC food.

The federally funded program provides food, health care referrals and nutrition education to low-income pregnant, breastfeeding and nonbreastfeeding postpartum women, as well as to infants and children through age 5 at nutritional risk. The Illinois program serves about 215,000 women and children each month.

"This is just the first step in knocking off fraud in the program," Schafer added. "We are also working with the state police to look into possible criminal violations related to the program and are looking at new methods of food distribution to stop the incidence of participants selling their food instruments to store owners, who, in turn, will redeem the food instruments with IDPH, although they never provided any food for them." ■

Ron Ackerman



LYDIA FONG, a high school sophomore from Hoffman Estates, won first place in a statewide poster contest to promote organ and tissue donor awareness. Secretary of State George Ryan presented Fong with the award April 21 at the Capitol in Springfield. Ryan said there is a vital need for organ donors in Illinois because 1,300 people are awaiting organ transplants.

Medicare spending less on surgical services

[CHICAGO] Medicare spending for surgical services has decreased for the second consecutive year, according to the American College of Surgeons. Recent data collected by the U.S. Department of Health and Human Services showed that Medicare spending on such services was .6 percent lower in the first six months of 1992 than the first six months of 1991. Spending for all other physician services increased by 8.5 percent during the same period.

Under the Omnibus Budget Reconciliation Act of 1989, HHS is required to monitor and report trends in Medicare spending for physician services. The monitoring process, known as the Medicare Volume Performance Standard, was established as an incentive to physicians to moderate growth in the volume of services they provide to their Medicare patients. A separate MVPS was created for surgical services.

According to ACS Director Paul Ebert, MD, these data on Medicare spending are not surprising, because surgical services remain relatively static from year to year. ■

Guide offers hope for those with HIV and AIDS

[MT. PROSPECT] The HIV Coalition for North Suburban Cook County has published a survival guide for individuals who have been newly diagnosed HIV-positive or with AIDS. HIVCO is a group of more than 200 medical and social service professionals and community members. The 216-page guide, "There Is Hope: Learning to Live with HIV," describes the realities and challenges of living with HIV.

"For some, testing positive is the worst thing that could ever happen to them," said book author and editor Janice Ferri. "For others, impossible as it sounds, it could turn out to be one of the best. Life is what you make of it – so is HIV."

"There Is Hope" answers basic questions about HIV and offers perspectives from medical and social service professionals. The book also explores how to find and work with a physician.

To help readers who are learning to cope with the disease, the book uses "voices of hope" – bylined narratives by HIV-positive individuals – which demonstrate how to do more than just survive or exist with HIV. The book is also designed to let readers know that they're not alone.

The publication is available at no charge to HIV-positive individuals. For more information about the book, contact HIVCO at (708) 294-6137. ■

PHYSICIAN FACTS

What's ailing Americans?

The following are the number and percent distribution of office visits by the 10 most frequently mentioned principal diagnoses in 1990. Numbers are in millions.

Rank	Principal diagnosis	Number of visits	Percent
1	Hypertension	27.310	3.9
2	Otitis media (middle-ear infection)	24.458	3.5
3	Normal pregnancy	23.561	3.3
4	General medical examination	21.043	3.0
5	Acute upper-respiratory infection	20.555	2.9
6	Health supervision of infant or child	18.676	2.7
7	Diabetes	15.303	2.2
8	Allergic rhinitis (allergy)	12.123	1.7
9	Bronchitis, not specified as acute or chronic	12.098	1.7
10	Acute pharyngitis (sore throat)	11.536	1.6

Source: National Center for Health Statistics, Advance Data, No. 214

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ISMS-backed bills continue to advance

LEGISLATION ROUNDUP: Lawmakers push bills supported by medicine. By Anna Brown

[SPRINGFIELD] Having made the leap from their houses of origin, some ISMS-supported measures have continued faring well. Action to date on these bills spurs hope that Illinois physicians will see some of the legislation they support passed into law this year. But before advancing to the governor's desk, bills must pass three readings on the House and Senate floors.

Passing in the Senate was H.B. 1974, sponsored in that house by Sen. J. Bradley Burzynski (R-Sycamore). Originally introduced in the House by Rep. Edgar Lopez (D-Chicago), the bill would amend the Medical Practice Act of 1987 by allowing visiting physicians to demonstrate or perform, in addition to study, certain subjects or techniques. The measure was passed 52-1.

A House bill prohibiting stays of disciplinary actions under certain conditions moved to second reading in the Senate May 3, and its Senate counterpart passed in the House by a vote of 116-0. H.B. 1971 was originally introduced by Rep. Joseph Kotlarz Jr. (D-Chicago). S.B. 601 was sponsored in the Senate by Sen. Peter Fitzgerald (R-Palatine) and in the House by Rep. Bob Biggins (R-Elmhurst). Both bills were prompted by a recent Illinois Supreme Court ruling allowing dentists to continue practicing dentistry until all disciplinary actions filed against them by the Illinois Department of Professional Regulation are resolved. In addition, all administrative and court appeals must be exhausted. The bills would preserve due process, allowing stays of disciplinary actions throughout the appeals process only when it could be proved that individuals posed no threat to the public.

Mandatory use of birth control would be prohibited under H.B. 671, a bill that advanced to second reading in the Senate May 3. Originally sponsored by Rep. Mary Flowers (D-Chicago) and introduced in the Senate by Sen. Earlean

(Continued on page 14)

Physicians gain House victories

FAILED BILLS: Unfriendly legislation dies in the House. By Anna Brown

[SPRINGFIELD] Despite a chilly attitude toward medicine's tort reform bills in the Illinois House, Illinois physicians have managed several successes during the 1993 legislative session. Two trial lawyer-backed bills, mandatory assignment bills and a bill advocating direct Medicaid reimbursement for nurse practitioners are among several ISMS-opposed measures that have been defeated. However, some of these proposals will likely return this year through amendment to Senate bills sent to the House.

H.B. 2111, a prejudgment interest bill, and H.B. 1369, a respondent-in-discovery bill, both sponsored by Rep. Louis Lang (D-Skokie), would have increased the malpractice burden in Illinois. ISMS opposed H.B. 2111 because it would have almost doubled awards and increased costs to physicians and professional liability insurers in Illinois, as well as further delayed an already backlogged court system. The bill would have affected all tort cases, not just medical malpractice cases, and would have generally increased health care and business costs in Illinois. The vote was 36 yes, 77 no, 2 present and 3 not voting.

H.B. 1369 would have allowed a plaintiff to file a pleading against a fictitious person or entity, while naming an actual person or entity as a respondent in discovery. Discovery would have been allowed to begin in lawsuits that lacked actual defendants. Current law requires at least one real defendant in lawsuits and mandates that plaintiffs in medical malpractice cases obtain a certificate of merit signed by a third-party physician. Legislative analysts argue that naming physicians as respondents in discovery when no actual defendant exists could nullify the affidavit requirement. The roll call vote was 22 yes, 86 no, 3 present and 7 not voting.

H.B. 552, sponsored by Rep. David Phelps (D-Eldorado), would have authorized birthing centers as alternative health care models. ISMS House of Delegates policy stipulates that such centers adhere to American College of Obstetricians and Gynecologists guidelines, such as the requirement that birthing centers be attached to hospitals. H.B. 552 was

(Continued on page 14)

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REPORT FOR *Illinois Physicians*

CLINICAL QUALITY STUDIES

The Health Services Research Department, in conjunction with the Medical Department, of Blue Cross and Blue Shield of Illinois (BCBSI) regularly carries out clinical quality studies, which are designed to determine if quality health care services, both clinical and administrative, are being provided to BCBSI members. BCBSI believes that many of these studies would be of interest to Illinois Physicians. Consequently, in this issue we are reporting on one of these studies. Other such reports will appear in the future.

HYPERTENSION AUDIT -- Given the frequency and significance of hypertension as a disease entity, as well as the availability of effective therapy to prevent its complications, BCBSI felt it appropriate to study certain aspects of the care of this disease for its insured members. As a result, an audit was performed in the fall of 1992 on BCBSI patients hospitalized for hypertension (HTN).

METHODS -- Hospital claims data were used to identify a cohort of members hospitalized in 1991 with a discharge diagnosis of essential hypertension, accelerated hypertension or malignant hypertension. Hospital records were then requested for a sampling of these admissions, selected randomly. Appropriateness criteria were taken from standard textbooks of medicine, with two areas of clarification:

a. Admissions were considered unnecessary if no signs or symptoms of threatened end organ damage were present.

b. Work-up for a possible secondary cause of the HTN was considered appropriate if any of the following applied: abrupt onset of severe HTN before age 25 or after 50; abnormal basic screening tests; symptoms suggesting an endocrine condition or an abnormal exam (renal bruit, palpable mass, etc.).

RESULTS -- Forty hospital records were reviewed. The average patient age was 48, and only 10% had no past history of known HTN. Blood pressures on admission ranged from 150-260 mm systolic to 100-176 mm diastolic. Ninety percent (90%) of admissions were considered justified, but 29% of all hospital days were found on retrospective review to be medically unnecessary. These days were generally lost by keeping patients in the hospital for diagnostic tests, once they had clinically stabilized.

A secondary cause of the HTN was searched for in 32.5% of cases, but only indicated in 15% of these cases according to the criteria. No secondary evaluations were diagnostic.

In all cases, the HTN was promptly controlled. There were no adverse outcomes.

CONCLUSIONS/FOLLOW-UP -- While the care provided was excellent and most admissions appropriate, two areas of over-utilization were identified: excessive lengths of stay, and excessive testing for possible secondary causes. An excellent review of detecting renovascular HTN was recently published which included suggested guidelines. This article is highly recommended.

(Mann SJ, Pickering TG: "Detection of Renovascular Hypertension" Ann. Int. Med. 117:845-53, 1992).

(Issue: 05/21/93 - BS)

Society leadership takes office

SOCIETY POSTS: Physicians assume new ISMS roles.

ISMS President Arthur R. Traugott, MD, an Urbana psychiatrist, leads the Society's new slate of officers for 1993-94. Dr. Traugott was installed during an April 25 ceremony at the ISMS Annual Meeting in Oak Brook.

Alan M. Roman, MD, of Flossmoor, was named ISMS president-elect by the House of Delegates during the Society's April 25 elections. Other new ISMS officers are First Vice President Raymond E. Hoffmann, MD, of Rockford; Second Vice President Joan E. Cummings, MD, of Hines; Secretary-Treasurer David B. Littman, MD, of Highland Park; Speaker of the House of Delegates Ulrich F. Danckers, MD, of River Forest; and Vice Speaker Richard A. Schmidt, MD, of Ottawa. Immediate Past President Arvind K. Goyal, MD, of Rolling Meadows, is the new ISMS at-large trustee.

Newly elected leadership includes Third District Trustees Dennis M. Brown, MD, of Schaumburg; Sandra F. Olson, MD, of Chicago; Aldo F. Pedroso, MD, of Chicago; and M. LeRoy Sprang, MD, of Evanston; Sixth District Trustee Robert F. Hamilton, MD, of Alton; Ninth District Trustee Phillip D. Boren, MD, of Carmi; and 10th District Trustee Ronald G. Welch, MD, of Belleville.


Robert F. Hamilton, MD

Illinois delegates to the AMA also were elected during the Annual Meeting. The following physicians will serve on the delegation until 1994-95: Albino T. Bismonte Jr., MD, of Gurnee; Silvana Y. Menendez, MD, of Belleville; Robert M. Reardon, MD, of Bloomington; Dr. Traugott; Dr. Welch; Alfred J. Clementi, MD, of Arlington Heights; Jere E. Freidheim, MD, of Burr Ridge; Dr. Goyal; Harold L. Jensen, MD, of Harvey; and Dr. Sprang.

Alternate AMA delegates with terms expiring in 1994-95 are James P. Ahstrom Jr., MD, of River Forest; Charles Drueck III, MD, of Wilmette; Earl E. Frederick Jr., MD, of Chicago; Dr. Olson; Biswamay Ray, MD, of Oak Brook; Clair M. Callan, MD, of Libertyville; Dr. Hoffmann; Alec B. Hood, MD, of McLeansboro; and Marc L. Schlesinger, MD, of Aurora.

The Illinois State Medical Inter-Insurance Exchange Board of Governors also elected officers to serve until 1996. Dr. Jensen will continue as chairman; Fred Z. White, MD, of Chillicothe, is vice chairman; and Irwin A. Smith, MD, of Northbrook, is secretary. Board members elected until 1996 are Peter A. Brusca, MD, of Carol Stream; David W. Cromer, MD, of Evanston; Lawrence L. Hirsch, MD, of Northbrook; Dr. Hoffmann; Eugene P. Johnson, MD, of Casey; Dr. Littman; and Walter W. Whisler, MD, of Chicago.

New officers of the Illinois State Medical Insurance Services Board of Directors include Dr. Clementi, who will succeed Dr. Boren as chairman; and board members Dr. Sprang; Dr. Roman; George T. Wilkins Jr., MD, of Edwardsville; Dr. Boren; and Dr. Welch. ■

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Please join us in honoring these outstanding Roche representatives who have distinguished themselves by a truly exceptional level of professionalism, performance and dedication to quality healthcare. Throughout the year, each of these award-winning individuals has consistently exemplified the Roche Commitment to Excellence and we're proud to invite you to share in congratulating them on their achievement.


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AMA perspective on health reform

ANNUAL MEETING: The AMA's board chairman discussed the association's role in reform.

By Anna Brown

[OAK BROOK] In an upbeat speech about Washington's possible changes to the U.S. health care system, Raymond Scalettar, MD, chairman of the AMA Board of Trustees, called for physicians to become involved in the process. Dr. Scalettar addressed his remarks to physicians attending the April 24 ISMS educational seminar on health care reform during the Society's Annual Meeting.


Dr. Scalettar

Dr. Scalettar cited good relations between the AMA and the president's health care reform task force, noting that the leader of the group's day-to-day operations, Ira Magaziner, "seems responsive" to medicine's concerns.

"The White House isn't just interested, they're actually listening. Today, Washington is AMA country," he told the Illinois physicians. But he also stressed the need for physician involvement in any reasonable reform package.

(Continued on page 17)

One congressman's view of health care reform

ACCESS: As a new member of Congress, a U.S. representative told ISMS where he stands on the struggle for reform. By Gina Kimmey



Wm. Daniels/The Photo Partners

U.S. Rep. Mel Reynolds

[OAK BROOK] Citing the AMA's concerns about the exclusion of physicians on the President's health care task force, U.S. Rep. Mel Reynolds (D-Chicago) called on Illinois physicians to share their ideas on health care reform. Reynolds is the only freshman congressman on the House Ways and Means Committee, which will have financial oversight for any health care reform that passes through Congress. He spoke at the April 24 ISMS Public Affairs Breakfast held during the 1993 Annual Meeting. "My door is always open and I always return my phone calls," he said. "I need your insight."

> *I'm open to any ideas as long as we have a system where, if I'm driving down the street and I don't feel well, I can go into any hospital and receive the care I need.*

Born in Mississippi, Reynolds moved to Chicago with his family as a young child. Following the death of his father, his family spent five years living in a Chicago public housing complex, relying on public assistance. As a young man, he watched as his grandmother suffered a heart attack and then died in an ambulance because paramedics knew the nearest hospital wouldn't accept her because she lacked health insurance. Reynolds said these early life experiences have given him a more personal perspective on approaching health care reform than many of his colleagues on Capitol Hill have.

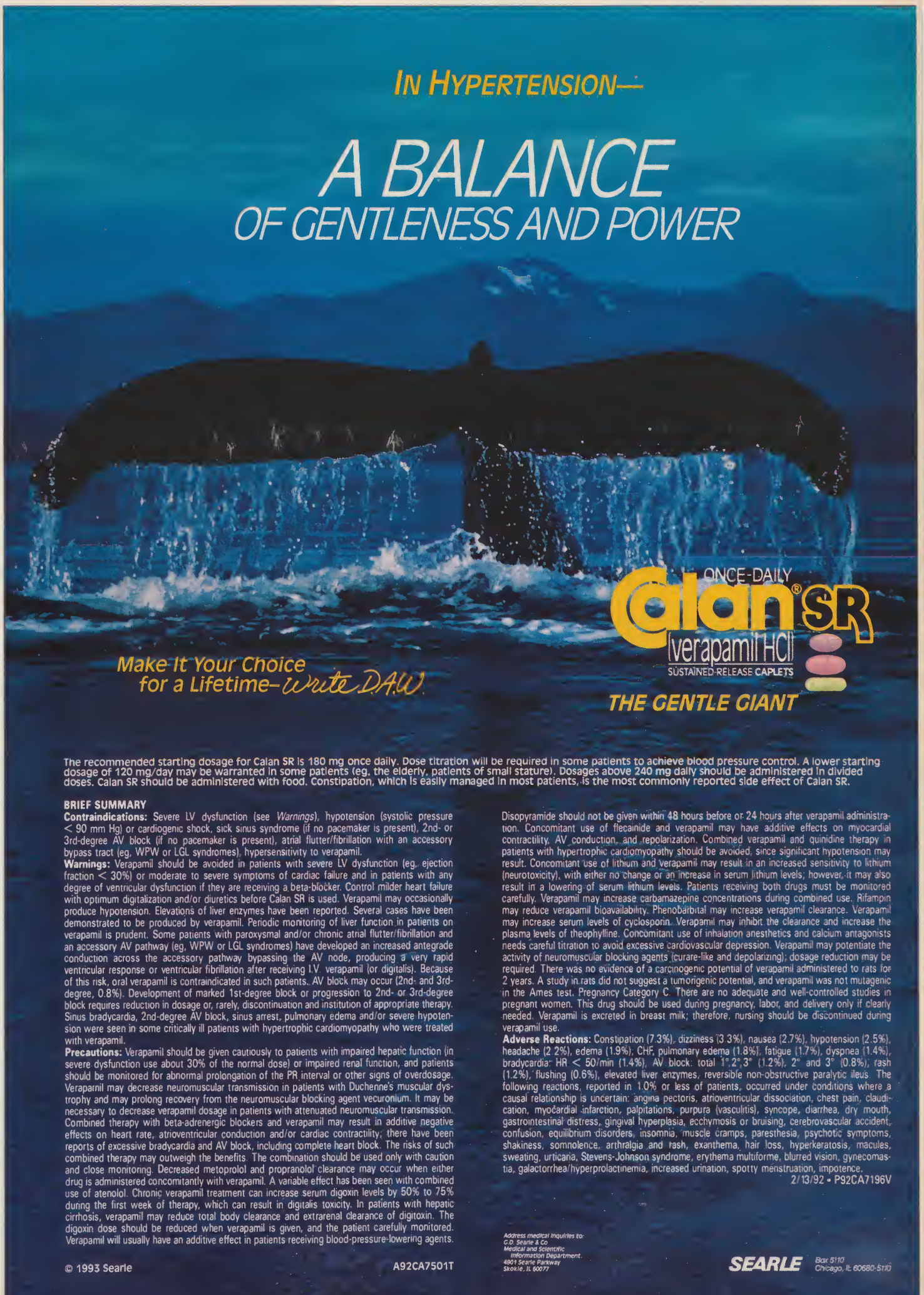
"I'm going to vote for anyone's plan, whether it's Hillary's, Bill's or yours, as long as it provides care for everyone," Reynolds said. "I've looked at lots of plans, and I'm open to any ideas as long as we have a system where, if I'm driving down the street and I don't feel well, I can go into any hospital and receive the care I need."

A STRONG SUPPORTER of gun control, Reynolds told the physician audience he is willing to listen to them and he hopes they are willing to listen to him in return. "We have accepted a society where we kill each other. We have to stop the madness." ISMS House of Delegates policy opposes ready accessibility to handguns without evidence of owner responsibility, and the Society has supported state legislation calling for owner liability laws, state-administered gun registration and more restrictive handgun licensing.

"Last year $1 billion was spent on uninsured gunshot victims," Reynolds said, adding that he believes the government should receive revenue from gun users to help fund health care. "Nothing is written in concrete as far as how the plan will be paid for."

According to Reynolds, the White House task force is under pressure to get health care reform under way this year. He met with First Lady Hillary Rodham Clinton just weeks before his ISMS presentation and said she "should not be underestimated. Whether you agree or disagree with her ideas, know that she understands the issues." The focus of health care reform, he said, should be on the substance of the various proposals, not their source.

"We may disagree, but I will always discuss it with you. We need to work together to get reform going. This is what I bring to the table: I am willing to talk, and I am willing to listen. Nothing will be accomplished if we don't start working together and giving each other's ideas a chance." ■



The recommended starting dosage for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food. Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

ISMS becomes part of the solution

At the 1993 Annual Meeting, the ISMS House of Delegates became part of the solution to the problem of health care reform by approving a "working plan" for statewide reform. The proposal provides a framework for building a detailed plan for Illinois. Specifics of the final version will incorporate input from businesses, government, patients, hospitals and other health care providers. A prerequisite for implementing the plan would be changes in the federal ERISA laws governing self-insured health plans.

The ISMS strategy now calls for expanded access to care through a guaranteed health benefit plan that provides a basic level of benefits to all state residents. A health care reform board – composed of physicians and other providers, patients, businesses and others – would determine the services to be covered. This care would be determined, in large part, by the amount of money society is willing to pay.

Those who can't afford health insurance would receive state subsidies to help them purchase coverage. In addition, health insurance reform measures, such as instituting community rating and limiting pre-existing condition clauses, would help provide coverage to everyone, regardless of past or present health status.

Under the proposal, patients would choose a provider, who would help coordinate their primary and specialized care. This approach is intended to ensure quality by emphasizing continuity of care, prevention and patient education. ISMS envisions care to be offered to consumers through a variety of practice settings, including fee-for-service, solo, small and group practices; and PPOs and HMOs.

The plan also addresses cost containment. First and foremost is medical malpractice reform, including a $250,000 cap on noneconomic damages. In addition, the plan increases physicians and other providers' responsibility to control costs. A resource based relative value scale similar to the one used by Medicare is proposed as the basis for physician-set fees.

Consumers would be required to pay deductibles, copayments or coinsurance to make them more aware of the costs of medical care. And out-of-pocket expenses would be reduced or waived for low-income residents. Insurance premiums would be based, in part, on behavior and would reward those with healthy lifestyles.

The ISMS plan is an evolving document meant to be improved and refined. The House of Delegates is to be commended for this positive action in statewide reform. And input from grassroots members can do nothing but improve the plan. Let ISMS know what you think.

PRESIDENT'S LETTER

Thanks to the ISMS House of Delegates

By Arthur R. Traugott, MD



We need something substantive if we're going to be a credible partner in the debate.

Thank you, House of Delegates, for passing in principle the ISMS Health Care Reform Plan. Immediately after our House meeting ended, I left for a meeting in Washington, D.C., on health care reform.

The landing pattern of the plane gave me a view of the Capitol mall, which was filled with people who were there for the gay and lesbian demonstration.

I watched the news that night. Appearing before marchers were politicians, but not the leaders who spoke to us at the AMA meeting. A congresswoman from Colorado presented the president's message. The crowd felt betrayed and accused President Clinton of failing to deliver on his promises to them.

What a contrast to the AMA meeting a month earlier. We didn't have to fill the mall to draw attention to our concerns about our patients. We said we wanted to be part of the solution in bringing about health care reform. Washington listened.

In Washington, I paid a visit to a member of our congressional delegation. He had received a copy of the ISMS Health Care Reform Plan that morning. I informed him that our plan was a starting point so that we could join others at the table where negotiations for health care reform were occurring. He was upset that we did not address Medicare, but he appeared relieved when I told him that ISMS was well aware of the problems of the Medicare system, which have to be addressed. The members of the ISMS ad hoc committee on health care reform believe Medicare reform could readily occur under our plan if it were adopted as a national plan.

When we concluded the visit with the representative, he said that he agreed with 75 percent of our plan. This was a significant change in his reception of our Society from the time he was presented with our Ten Principles of Health Care Reform.

This all goes to prove that we need something substantive if we're going to be a credible partner in the debate. Thank you, delegates of our House, for making this possible.

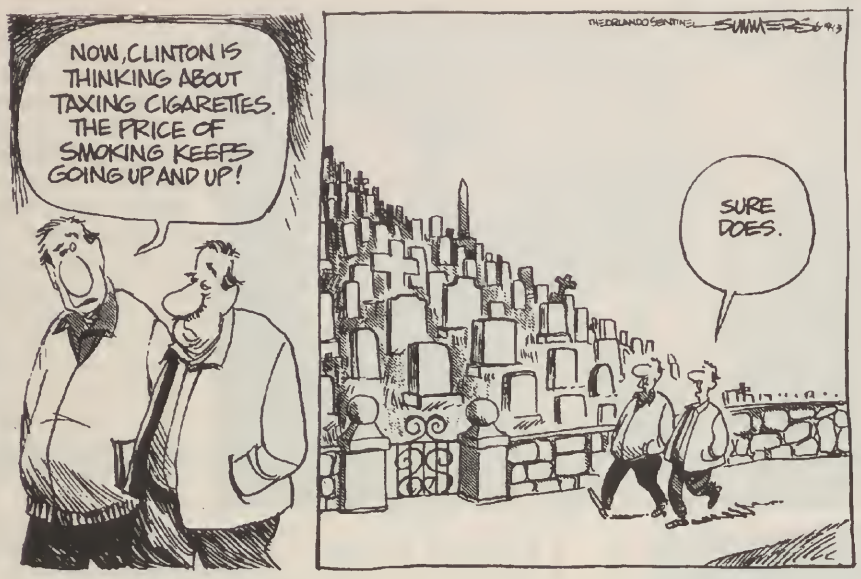
Let me also share with you a concern of mine that arose from a presentation at that same meeting. I heard that the Clinton health plan was no longer a basic plan but a comprehensive one. How could this be if cost containment is the driving force of health care reform? For an MD following the developments and trying to participate in reform, this came as a big surprise.

It reminded me of the story of a farmer who wanted to get into the poultry business. He had limited finances, so he found a city partner. One morning the farmer found that a poultry epidemic had swept through the flock and half of the chickens had died. He felt obliged to let his partner know of the turn of events. He called his partner in the city and said, "I thought I'd better let you know that an epidemic struck our flock and all of *your* chickens died."

Are we the city partner who is cooperating in the health reform venture? Didn't we enter into this with the belief that a basic benefit plan was a reasonable approach? How can the administration now be promoting a comprehensive plan?

One speaker, an MD on the task force, gave us a clue. He informed us that some of our medical treatments are optional and that we physicians will be asked to identify those optional services. Specialists will be asked to choose their most important procedures, with the implication that the remainder are optional.

That kind of thinking can lead to bare-bones medical care. If all of those pared-down services are incorporated into a health insurance plan, then one arrives at a goal of comprehensive coverage. Maybe more than our half of the chickens died. Are the American people going to be given an empty philosophical plan couched in jargon that gives them more unrealistic expectations of health care, or will they receive a plan adequate to meet their realistic needs?



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LETTERS

Economic credentialing bypasses patient choice

As the great national health care debate takes center stage, I urge all Americans to consider carefully what a system emphasizing the economics of health care could mean for the delivery of care in the United States.

I am a cardiovascular and thoracic surgeon whose west suburban medical practice recently became a casualty of economic credentialing. This is a highly controversial practice whereby hospitals weigh physicians' past referral rates and other economic information over their experience and knowledge as a means of granting staff privileges.

A few months ago, our private practice was informed that the suburban hospital with which we are affiliated had created an exclusive contract with a new group of cardiovascular surgeons. The procedure this group would handle is one of our practice's specialties and represents 60 percent of our business. We were shocked at the sudden decision, especially since we had made a major commitment to this hospital, substantially decreasing our work at other area hospitals. As physicians, we are focused primarily on our patients' well-being. Moreover, we wanted to see the hospital's cardiac surgery program become a success. We hoped that our efforts would increase the hospital's revenues.

Certainly, we are concerned about how economic credentialing affects our practice. But, in a larger sense, this situation raises some serious concerns about patients' rights to make health care choices. If hospitals begin making decisions unilaterally – based exclusively on the economics of medicine without regard to physician loyalty and experience – patients will suffer the consequences.

Consumers will not be able to go to their local hospitals and receive care from physicians they have chosen. Doctors will not be able to refer their patients to specialists they know and trust. Instead, patients may receive care from physicians whose practices are under contract by the hospital and best suit its bottom line. When an institution violates its staff's rights, how can it be trusted to protect its patients' health and rights?

Plans for a national health care policy are beginning to take shape. Now is the time we must urge our policymakers to craft a plan that focuses not only on economics, but on the health care needs and options for American patients.

– Raj B. Lal, MD
Lombard

Economic credentialing mocks physicians

Economic credentialing is opprobrium. Eager hospital administrators use it as a scalpel, turning time-honored medical credentials into confetti and mocking the altruistic impulse of most physicians.

Hospitals keep a keen eye on the bottom line. Their administrators preside over product-line managers and have significant funding for slick marketing campaigns. And their boards typically lack physician representation, except as occasional token members. Much has been written about physicians' loss of power within hospitals and their diminished control over hospital decision making.

The eloquence of altruism in medical practice is sullied by hospital administrators' use of economic credentialing. The missionary slogans gracing many hospitals ring hollow behind the tarnished image of our post-modern hospitals. A recent American Hospital Association ad hoc committee on the elderly concluded that "today's hospital must ... maximize financial margins by promoting services that optimize DRG performance ... and promote high-margin DRG services by marketing to appropriate subsegments of the older-adult market."

Two Springfield-area hospitals are anxious to expand their market share and are engaged in a medical arms race, flaunting their technological pyrotechnics. Medical staff leaders who yield to hospital administrators' agenda of economic credentialing are doing a great disservice to our friends – our patients.

– Neni Prasad, MD
Springfield

GUEST EDITORIAL

Caps *would* help

By Kenneth A. Vatz, MD

In March, the Evanston Review *and the* Winnetka Talk *ran a guest editorial written by a consumer advocate who opposes caps on noneconomic damage awards and supports single-payer, government-run health care reform. The following is Dr. Kenneth Vatz's response to that op-ed piece.*

In a March 4 guest essay ("Illinois should act on health-care reform"), Robert Creamer, executive director of Illinois Public Action (a self-styled consumer group), engaged in a backdoor, misleading lobbying effort against [S.B. 344 and H.B. 1432] state legislature bills placing caps on noneconomic awards in medical malpractice suits. Mr. Creamer cuts a wide swath, at once mischarging the impact of caps and proclaiming the failing Canadian "approach to national health insurance ... as an excellent model for reform."

In February, Congressional Budget Office Director Robert Reischauer testified to a U.S. House committee that malpractice insurance premiums make up less than 1 percent of total [health care] costs. Mr. Creamer conveniently turned that correct figure (about $9 billion!) for malpractice premiums alone into "medical malpractice costs," in an attempt to convince us that the costs of our present medical malpractice tort system are somehow limited to the insurance premiums.

> *The pressure on the physician not to 'miss something' pervades our society.*

As reported in the Feb. 3, 1993, issue of the *Washington Post,* a recent study by the National Medical Liability Reform Coalition, headed by Robert J. Rubin, former assistant secretary of the Department of Health and Human Services, estimates the cost of defensive medicine – "care provided solely to avoid malpractice claims" – at approximately $10 billion in 1991 and about $15 billion in 1998 (in 1991 dollars). This is [in addition to] the $9 billion in premiums. Using "broader assumptions," Rubin calculated the cost of defensive medicine from 1991-98 to be as high as $148 billion.

According to Mr. Creamer, the Association of Trial Lawyers of America argues that "much of what is called defensive medicine would probably be provided to patients in the absence of legal concerns, [since it] improves the accuracy of medical diagnosis." In truth, the pressure on the physician not to "miss something" pervades our society. It comes directly from patients and families, but most often from the Damoclean threat of a malpractice suit.

Consider an all-too-common example from a neurologist's practice: An otherwise healthy patient complains of headaches and expresses anxiety about the possibility of a brain tumor. After taking a careful history and finding the neurological examination to be normal, the neurologist judges this patient's chance of harboring a brain tumor to be no greater than that of the asymptomatic general population. There would likely be little danger in waiting a month or so while observing the patient's response to symptomatic treatment. But most neurologists will order a costly MRI brain scan anyway, with the justification or rationalization of needing to "reassure the patient." Now, is this defensive medicine or is it good medicine? Similar clinical scenarios occur thousands of times a week in this country, and clearly we no longer have the luxury of holding medicine to the standard of a 100-percent confidence level in diagnostic accuracy.

Tort reform must accompany any major change in our health care delivery system. Reasonable caps on only the noneconomic losses – pain and suffering, loss of consortium and other real but intangible losses that cannot be accurately measured – have been enacted in more than 15 states, and should be put into place in Illinois. Economic costs, such as past and future medical bills and loss of income, should and will continue to be awarded in full and with no monetary limit to truly injured patients.

Whatever system we eventually decide upon – and it will be some form of managed care – we must develop specific and detailed practice guidelines and parameters on a national level (with variation for only the availability of technology), the adherence to which will immunize the physician from malpractice judgment in that particular case. Applying this concept to the headache example above, the physician could avoid the unnecessary MRI scan, the system would save money and the patient would be reassured that some "higher authority" did not deem the test necessary at this point.

Something tells me that the Association of Trial Lawyers of America might not favor my solution (for reasons all too obvious), but Mr. Creamer should approve if his real agenda is the lowering of costs and the promotion of good medical practice. I agree with him on the need for health care reform, but not with his single-payer health insurance plan solution, as introduced last year in House Bill 2774 by his wife, state Rep. Janice Schakowsky (D-Evanston). The single-payer health insurance plan, for which the Canadian system is a model, has been deemed unworkable by both liberals and conservatives. Nonetheless, Canada's medical malpractice system, which for years has capped noneconomic damages, is one of the Canadian system's few redeeming features.

Our country needs careful thought and not pat answers to a $900 billion problem.

Kenneth A. Vatz, MD, is a neurologist in private practice in Arlington Heights.

May and June award winners go the extra mile

Two physician-nominated "primary care people" are the winners of the May and June ISMS Employee of the Month awards. Field representatives Peter Gallagher and Dennis Gragert each received recognition plaques and checks for $200 after they were named outstanding employees committed to service during a May 3 award ceremony.

"These two employees indeed work hard," said ISMS Chief Operating Officer Jeffrey M. Holden in presenting the awards. "They are a great source of ISMS expertise, and they know a great many grass-roots physicians. They also serve as resources on downstate physicians for other ISMS employees."

Holden explained that new field reps often come to ISMS with little knowledge of medicine but soon become experts. Their travels throughout the state acquaint them with current physician issues in even the smallest communities, and they serve as a vital link between ISMS and county medical societies.

Their physician nominator expressed appreciation for the long hours of travel Gallagher and Gragert devote to the

(Continued on page 23)

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May and June Employee of the Month award winners Dennis Gragert (left) and Peter Gallagher received plaques and checks in honor of their service to physicians and ISMS employees. The two field representatives serve as vital resources to staff and as ISMS liaisons to physicians throughout the state.

BECAUSE APPROXIMATELY 60% OF PATIENTS WITH PERSISTENT ANXIETY MAY EXHIBIT DEPRESSIVE SYMPTOMS...[1]

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Now indicated for the relief of persistent anxiety with coexisting depressive symptoms.*

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▲ Relief of anxiety symptoms begins within 1 week, progresses steadily through the fourth week of therapy.[3]

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▲ The more commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%).

Progressive Relief of Persistent Anxiety.

*BuSpar is not indicated for the relief of primary depressive disorder.

Please see references and brief summary on adjacent page.

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BuSpar® (buspirone HCl)

References: 1. Data on file, Bristol-Myers Squibb Company. **2.** Cohn JB, Bowden CL, Fisher JG, Rodos JJ. Double-blind comparison of buspirone and clorazepate in anxious outpatients with or without depressive symptoms. *Psychopathology.* 1992;25:10-21. **3.** Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multistudy, double-blind evaluation of buspirone. *Neuropsychobiology.* 1989;21:124-130. **4.** Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med.* 1987;82(suppl 5A):20-26. **5.** Newton RE, Marunycz JD, Alderdice MT, Napoliello MJ. Review of the side-effect profile of buspirone. *Am J Med.* 1986;80(suppl 3B):17-21.

Contraindications: Hypersensitivity to buspirone hydrochloride.

Warnings: The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

Precautions: ***General*** – *Interference with cognitive and motor performance:* Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable; therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients: Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdraw patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

Possible concerns related to buspirone's binding to dopamine receptors: Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

Information for Patients – Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding; and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

Drug Interactions – Concomitant use with other CNS active drugs should be approached with caution (see **Warnings**). Concomitant use with trazodone may have caused 3- to 6-fold elevations of SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

Carcinogenesis, Mutagenesis, Impairment of Fertility – No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

Pregnancy: Teratogenic Effects – Pregnancy Category B: Should be used during pregnancy only if clearly needed.

Nursing Mothers – Administration to nursing women should be avoided if clinically possible.

Pediatric Use – The safety and effectiveness have not been determined in individuals below 18 years of age.

Use in the Elderly – No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

Use in Patients with Impaired Hepatic or Renal Function – Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

Adverse Reactions (See also Precautions): ***Commonly Observed*** – The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

Associated with Discontinuation of Treatment – The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

Incidence in Controlled Clinical Trials – Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: *Cardiovascular:* Tachycardia/palpitations 1%. *CNS.* Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. *EENT:* Blurred vision 2%. *Gastrointestinal:* Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. *Musculoskeletal:* Musculoskeletal aches/pains 1%. *Neurological:* Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. *Skin:* Skin rash 1%. *Miscellaneous:* Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

Other Events Observed During the Entire Premarketing Evaluation – The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. *Cardiovascular* – frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. *Central Nervous System* – frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. *EENT* – frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. *Endocrine* – rare: galactorrhea, thyroid abnormality. *Gastrointestinal* – infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. *Genitourinary* – infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. *Musculoskeletal* – infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. *Neurological* – infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. *Respiratory* – infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. *Sexual Function* – infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. *Skin* – infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. *Clinical Laboratory* – infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. *Miscellaneous* – infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

Postintroduction Clinical Experience – Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

Drug Abuse and Dependence: ***Controlled Substance Class*** – Not a controlled substance.

Physical and Psychological Dependence – Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

Overdosage: ***Signs and Symptoms*** – At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

Recommended Overdosage Treatment – General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

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'Case in Point' looks at problem pregnancies

PAGE 10

ISMIE Update

More guidelines for medical records access

PAGE 11

Practicing without a license jeopardizes liability coverage

JULY 31 DEADLINE: Failing to renew a license to practice medicine carries serious implications for physicians insured by ISMIE. By Tamara Strom

[CHICAGO] Don't underestimate the consequences of failure to renew your medical license this summer. The triennial license period ends July 31; physicians who do not reapply for medical and controlled substance licenses by that date will technically be practicing without a license.

That means Exchange policyholders will have no medical malpractice coverage while they are practicing without a license, said Harold L. Jensen, MD, chairman of the Exchange Board of Governors. "If you are not properly licensed in Illinois, you are not covered under your Exchange policy. This could leave a gap in coverage that could present dire implications for physicians if a claim should arise.

"With no insurance coverage, physicians lose the benefits of transfering risk gained by purchasing a liability policy," he continued. "Physicians in this situation have no protection for their personal assets if an adverse judgment is entered against them." It would be difficult, if not impossible, for physicians to secure liability insurance from any company for the time they practice without a license, Dr. Jensen said.

FAILING TO MEET the license renewal deadline also exposes physicians to possible actions by the Illinois Department of Professional Regulation, Dr. Jensen noted. Practicing medicine on an expired license is grounds for discipline by the Illinois State Medical Disciplinary Board. Dr. Jensen urges physicians to do everything they can to avoid this potentially serious situation by renewing their medical licenses on schedule.

In mid-May, IDPR mailed renewal forms to licensed Illinois physicians. Medical licenses obtained during this renewal cycle will run from Aug. 1, 1993, to July 31, 1996. Physicians who do not receive the renewal package by mid-June should contact IDPR at (217) 782-0458. Those physicians who have moved within the past three years and have not submitted a change-of-address form to IDPR may not receive a renewal form at their current address. The department encourages all doctors to keep their current address on file with IDPR to avoid the possibility that critical correspondence may fail to reach them on time.

> *If you are not properly licensed in Illinois, you are not covered under your Exchange policy.*

CONTROLLED SUBSTANCE LICENSES for physicians must also be renewed by July 31, IDPR said. New rules regarding physicians' controlled substance licenses will be enforced this renewal cycle, according to the department. The changes are intended to ease physicians' administrative hassles by requiring controlled substance licenses for only those locations where they store such drugs. The previous rules mandated that physicians have a license for each practice location. The department stressed, however, that all physicians who prescribe controlled substances must apply for at least one license, even if they do not store drugs in their office.

Renewed controlled substance licenses cost $15; an additional $15 fee is required for each practice location for which a license is renewed. Doctors may send these fees together with their $300 ($600 for out-of-state physicians) medical license fee, provided that all the necessary paperwork and applications for each license requested are submitted at one time, IDPR said.

Physicians should be advised that according to a new state law, license renewal forms include questions about their child support payment status. The law mandates certification that physicians paying court-ordered child support are no more than 30 days delinquent on these payments. Noncompliance with this requirement is grounds for nonrenewal of medical licenses, IDPR said. ■



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ATTENDEES AT THE ISMIE Luncheon browse through Exchange brochures, including the new annual report. The luncheon followed the House of Delegates address on the state of the Exchange by ISMIE Board of Governors Chairman Harold L. Jensen, MD. During the lunch, delegates received more detailed information about new rates and changes for the coming policy year.

MALPRACTICE ROUNDUP

Negligent reading of Pap smear

A case recounted in the *Malpractice Reporter* asked whether the hospital or the hospital's director of pathology was responsible for negligently reading a plaintiff's Pap smear. Over several years, the plaintiff's gynecologist took five Pap smear specimens to the hospital's pathology department. Both the hospital and the department director were charged with having improperly read and analyzed the specimens, resulting in a failure to diagnose the patient's cervical cancer.

The director sought summary judgment, arguing that his director position was an insufficient basis for holding him vicariously liable for the alleged negligence of other hospital employees who had prepared the reports. The hospital claimed that the specimens were submitted directly to the director, who was compensated for analyzing them. The lab work was then referred to another physician, who conducted the allegedly negligent analysis and prepared the report. This physician was compensated by the director.

The court denied the director's motion, ruling there was sufficient evidence to create a factual issue regarding the director's possible vicarious liability. ■

The cost of medical liability

Insurance premiums paid by physicians and other health care professionals have financed the majority of the medical liability system's costs, according to the AMA's Specialty Society Medical Liability Project. Liability insurance premiums have increased at an average annual rate of 15.1 percent — more than four times the 3.6 percent general inflation rate. During the 1980s, physicians' medical liability insurance costs tripled nationwide, rising from $1.7 billion in 1982 to $5.6 billion in 1989 and outpacing all other office practice expenses. In addition, between 1988 and 1991, premiums paid by community health centers increased from $30 million to $60 million, consuming 10 percent of the federal funds allocated to these centers.

The project also reported that of the total expenditures for physicians' services in 1989, 17.6 percent was spent on liability premiums and defensive medicine. Seventy-eight percent of U.S. physicians said the threat of malpractice suits caused them to order tests they might otherwise consider unnecessary; the percentage was even greater among hospital-based physicians (87 percent), surgeons (86 percent), and young physicians (84 percent). ■

Case in Point

Histories and testing vital in problem pregnancies

By Kathleen Furore

Presenting complaint and initial diagnosis: A 30-year-old female with a history of two premature deliveries (34 weeks and 24 weeks) was seeing an Ob/Gyn for her third pregnancy. The physician – who had taken an oral history but did not have the patient's previous records – had diagnosed the pregnancy on her third visit. On the first visit, he detected an enlarged uterus, but expressed no concern. She made a second appointment because of vaginal swelling and pain during intercourse. The physician found her uterus to be normal in size and said constipation was causing her problems.



When the physician saw the patient for the third time, she was eight weeks' pregnant. Because of her history, he ordered a test for beta strep colonization on the cervix – a condition he suspected had caused her premature births. Because the culture was negative, the doctor ordered no more tests and told the patient to see him monthly. During her 20-week exam, her uterus was abnormally enlarged. After an ultrasound disproved the physician's suspicion of twins, no further testing was done.

The case in brief: Before her sixth appointment, the patient entered the hospital with a bulging bag of waters. When her membrane ruptured, her cervix was dilated only 3 to 4 cm, but it progressed to complete dilation. The physician performed a spontaneous vaginal delivery. A neonatologist was also present. The patient's 2-pound baby boy died five days later of complications from premature birth.

After losing her third child, the patient consulted another physician to discuss her history and the risk of experiencing future premature labors. That doctor advised her to be tested for cervical incompetence and uterine malformation – two possible causes of premature labor for which she had never been tested – before trying to conceive again.

The resulting claim: The patient sued the Ob/Gyn who had treated her during her third pregnancy for failure to take a thorough history, obtain her previous medical records and perform tests that may have revealed the cause of her premature labors and resulted in treatment that may have saved her baby.

The outcome of the claim: The case was settled for $200,000.

The points this case makes: Obtaining records and documenting conversations and treatment is vital, from patient-care and risk-management perspectives, according to ISMIS Board Member and ISMS Third District Trustee M. LeRoy Sprang, MD, an Ob/Gyn at Evanston Hospital; and Ian Sherman, a partner in the Chicago law firm of Rooks, Pitts & Poust.

"The failure to obtain prior records really led the doctor in this case down the primrose path," Sherman said. "In today's liability-sensitive climate, it's prudent to go to any reasonable lengths to get past records, especially if there's a history with multiple problems. And doctors should be able to show they've taken steps to obtain those records. It's an odd thing, but from a jury's point of view, if it really happened and you didn't write it down, it didn't happen. If a patient says, 'He didn't ask' or 'He didn't tell me,' your credibility will be questioned."

"You have to have good records to provide good care," echoed Dr. Sprang, a former member of the Exchange's Risk Management Committee. "It's always important to take a history, get records and document things as much as possible. It is most significant when a patient comes in with a history that should set off red flags."

Dr. Sprang said the attending physician in the case had enough information from the patient's oral history to determine that she was at risk and that an incompetent cervix was one possible cause of her premature labors.

"It was a mistake to rule out other causes simply because there was no beta strep infection. You have to consider infection, but you shouldn't rule out things like cervical incompetence and uterine malformation," he said, adding that the physician should have checked the patient for each of those conditions.

Dr. Sprang also said the physician should have performed an ultrasound at 12 weeks to determine viability and conducted gentle internal exams every two weeks to check for signs of effacement or dilation. He observed that a cervical cerclage should have been performed if effacement or dilation were indicated.

"There has been some criticism that too many cervical cerclages are performed, but I lean toward being extremely careful and doing it at the first sign of a problem," Dr. Sprang continued. "Catching it early is best, but sometimes, even with the bag down in the vagina, you can put a patient in the hospital and stitch the cervix closed."

ALTHOUGH THIS CASE was settled for $200,000, it is not unusual for plaintiff attorneys to request much larger awards in cases involving a child or a stillborn baby, Sherman said.

"It is now state law that parents can be compensated for future loss of what would have been received from the continued life of the decedent," Sherman explained. "Ten years ago, death cases weren't worth as much as injury cases because there was no such thing as loss-of-society damages. Now it's an open checkbook, and there's no guidance or cap. Loss-of-society claims tend to play on the emotions of the jurors and ultimately increase awards. And there is a sympathetic situation when it involves the loss of a baby."

TO MAXIMIZE CARE and minimize litigation risks, Dr. Sprang and Sherman advised physicians to take these precautionary steps:

- Use a standard, acceptable prenatal record-keeping form or develop one that asks for a patient's history and identifies such risk factors as prior premature labors, diabetes, Rh incompatibility and hypertension.
- Ask patients to complete forms requesting prior records. Date and keep a copy of each form. If records aren't received, ask for them again and document your requests.
- Document everything – discussions of risk factors, test results, missed appointments and delivery reports.
- Write notes when events occur. Dictate all deliveries – vaginal and Cesarean section – immediately; then read the dictation for accuracy. If there is an error, draw one line through it, and date and initial it immediately. A dictated delivery note can be a useful defense tool.
- Determine what risk you are comfortable managing. Decide when you should get another physician's opinion, when you should request transfer of management and when delivery in a Level 2 or Level 3 hospital is indicated. ■

"Case in Point" is a regular feature using hypothetical case histories to illustrate loss-prevention maxims.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

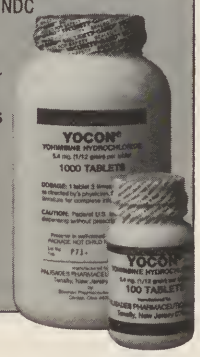
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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More guidelines for medical record access



Sexually transmitted diseases must be reported to IDPH, according to state law [410 ILCS 325/1 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 111 1/2, par. 7401 et seq.], and 77 Ill. Adm. Code 693. Except under strict circumstances, IDPH is bound by the following guidelines:

1. All information and records held by IDPH and its authorized representatives relating to known or suspected cases of sexually transmissible diseases are strictly confidential and exempt from inspection and copying under the Freedom of Information Act [5 ILCS 140/7 (1992)], formerly [Ill. Rev. Stat., ch. 116, par. 207, as amended by Section 11 of the Act] (Section 8(a) of the Act).

2. Such information will not be released or made public by IDPH or its representatives, by a court or parties to a lawsuit upon revelation by subpoena or by a court conducting proceedings authorized by Subsection (c) of Section 6 of the Act, except when:
- All individuals to which the information applies give their consent (Section 8(a)(1) of the Act);
- The information is used for statistical purposes, and medical or epidemiologic information is summarized so no person can be identified and no names are revealed (Section 8(a)(2) of the Act);
- The information is given to medical personnel, appropriate state agencies, such as the Department of Children and Family Services, or courts of appropriate jurisdiction to enforce the provisions of the Act (Section 8(a)(3) of the Act);
- The information is given to individuals whom IDPH determines are or have been at potential risk of HIV transmission pursuant to Section 5.5 of the Act (Section 8(a)(4) of the Act);
- The release is authorized by the AIDS Registry System regulations listed in (77 Ill. Adm. Code 697.210);
- The release is authorized by the AIDS Confidentiality Act detailed in (77 Ill. Adm. Code 697.140);
- The information is provided to a school principal pursuant to Section 697.400 of the AIDS Confidentiality and Testing Code (77 Ill. Adm. Code 697.400); or
- The disclosure is made pursuant to a subpoena, meaning such information will be sealed by the court from further examination, except as deemed necessary by the court to reach a decision and unless otherwise agreed to by all parties (Section 8(b) of the Act).

3. A court hearing a request for the issuance of a warrant as authorized in Subsection (c) of Section 6 of the Act conducts such proceedings in camera. A record will be made of authorized proceedings that will be sealed, impounded and preserved in the records of the court to be made available to the reviewing court in the event of an appeal (Section 8(c) of the Act).

4. No IDPH employees or authorized representatives may be examined in civil, criminal, special or other proceedings, concerning the existence or contents of pertinent records of a person examined or treated for an STD by IDPH or its representatives. Further, no employees or representatives may be examined concerning the existence or contents of such reports received from a private physician or private health care facility without the consent of the person examined and treated, except in proceedings under Section 6 and 7 of the Act (Section 8(d) of the Act). Keeping such information in a separate file would be appropriate.

5. All information and records held by the IDPH and local health authorities pertaining to health care contact risk assessment and notification activities are confidential and exempt from copying and inspection under the Freedom of Information Act. Such information and records may not be released or made public by IDPH or local health authorities, and are not admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency or person, and are treated the same as information and records subject to the provisions of [735 ILCS 5/21-101 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 110, par. 21-101 et seq.] except in certain instances.

For specific guidelines, see the ISMS brochure "A Physician's Guide to Medical Record Access and Retention." ■

Editor's note: This is part of a series on medical-legal issues written by the ISMS Medical Legal Council. These guidelines do not necessarily represent ISMS policy. They address legal concerns that physicians commonly express to ISMS and are intended to serve as only a guide for physicians, not specific legal advice.

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PORT

Tending to pa

A new leader hopes to help Illinois pi
by working together o

BY GIN
PHOTOS BY



Growing up in Kansas, he knew that he wanted to be a physician by the time he reached the eighth grade. But his father wanted him to be a minister. "And there was no room for negotiation. So I had to very stubbornly embark on my course of becoming a doctor," said Arthur R. Traugott, MD, an Urbana psychiatrist and newly installed ISMS president.

He began his postgraduate training intent on specializing in internal medicine. But at the end of his internship at the Cleveland Clinic Foundation, he completed a rotation through the psychiatry program and began considering a career in psychiatry. "For the first time, I experienced that psychiatry had a role in the treatment of acutely medically ill patients, as well as in dealing with other specific problems."

By the time he made his final decision about his specialty, all the psychiatric residency positions were filled. So he spent a year as a resident in internal medicine – a time he now regards as one of the best of his life. "I learned more about medical problems and psychiatric problems and was better able to see in my own mind where the two fit together. I believe that psychiatry has a much more active role to play in the delivery of primary medical care than ever before."

DR. TRAUGOTT'S INVOLVEMENT with organized medicine began early in his career in Urbana in the 1970s. The psychiatrists at one of the community hospitals where he practiced were upset with the Medicaid reimbursement system and arranged a meeting with Illinois Department of Public Aid representatives. During that meeting, Dr. Traugott realized that these public aid officials were not in a position to change the system. "While some of my colleagues saw the meeting as an exercise in futility, to me it had opened a new door. I found myself asking the question, If we can't resolve the problem here, then where do we go?"

Dr. Traugott took matters into his own hands, contacting the Champaign County Medical Society and becoming active in organized medicine. His first position at the county society was as a member of the Committee on Alcohol and Drug Addiction. Three years later, in 1976, he joined the ISMS Council on Mental Health and Addiction and served as that council's chairman from 1978-80. Seeking a more active role within ISMS, he was elected Eighth District trustee in 1982, and as he put it, "one thing led to another."

In psychiatry, patient appointments for therapy sessions are longer than the typical 15-minute visits with other physicians, Dr. Traugott said. Psychiatrists are held to a different standard of patient confidentiality, and patients may be reluctant to share personal or emotional troubles with an unfamiliar psychiatrist covering for their regular doctor. He believes these conditions contribute to many psychiatrists' difficulty in participating in organized medicine. Their schedules are usually less flexible, and their patients are seen on a continuing basis, with appointments that tend to be scheduled at a regular time on the same day of the week. "If I were a solo-practitioner psychiatrist, I don't think I would be able to break away from my practice and spend the time with ISMS that I do."

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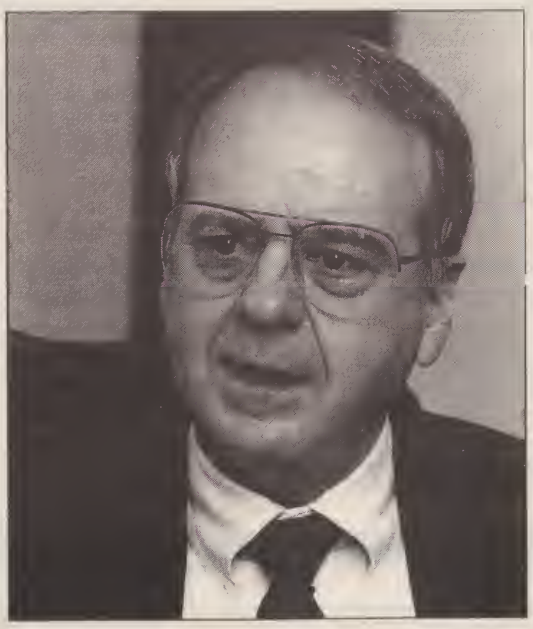
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actively involved with organized medicine as are some of the ISMS and county medical society leaders, but Dr. Traugott said this does not diminish the contributions they make to the profession. He asserts that delivering personalized, high-quality care to patients is the most critical aspect of physician involvement. "I think that too often the grass-roots-level doctor doesn't realize at what level he or she can actually participate."

Dr. Traugott said physicians' participation as patient advocates can take many forms. "Whether it's testifying in Springfield or participating on an ISMS committee or council, or at the county medical society level or at the hospital medical staff level, every step we take is really participation in the name of our profession."







DR. TRAUGOTT WAS THE FIRST psychiatrist to join the multispecialty group at Urbana's Carle Clinic Association, becoming head of the division of psychiatry in 1972. "Our program there has been one of being intimately involved with our medical colleagues. The closer we are, the more able we are to see common ground and understand that all those pieces of patient care do fit together," he said.

Many physicians seem to have lost this sense of community, which Dr. Traugott said he perceives as a problem in the profession. He contends that medicine has splintered into specialty groups intent on identifying and defending "specialty turf," leaving the profession fragmented and unfocused on taking care of the "whole patient." He said this is a factor in the public's skewed perception that medicine is a business and physicians are looking out for their own interests. "If we are going to change things and achieve health care reform, we are going to have to be willing to share in the price of what that reform means. If we truly do have system reform, all of us are going to have to contribute to it, and all of us are going to gain from it."

As chairman of ISMS' five-member ad hoc committee on health care reform, Dr. Traugott said one of his primary presidential goals is promoting physician involvement in the reform process. "I believe that the way we participate best is by going back to the roots of our professionalism, and that is tending to the needs of our patients. When that is our primary focus, all the other matters fall into place."

The committee's work culminated this spring

I think having a substantive plan shows that the Society is a serious negotiator and that we are serious about health care reform.

in a physician-driven, written approach to health care reform in Illinois. Although the document is a work in progress with many details still to be addressed, Dr. Traugott said he is pleased that physicians now have a strategy they can take to the negotiating table. "I believe having a substantive plan shows that the Society is a serious negotiator and that we are serious about health care reform."

IN ADDITION TO HIS DUTIES with ISMS, Dr. Traugott is actively involved with the American Group Practice Association, serving as chairman of the Governmental Relations Committee. Away from his professional life in Urbana, Dr. Traugott and his wife, Shirley, volunteer for many community and public service organizations. The Traugotts have been married for 29 years and have two children. Their son, David, is a junior at Illinois Wesleyan University majoring in math, and their daughter, Andrea, recently completed her high school studies and is attending Parkland College.

Dr. Traugott credits his colleagues in Urbana for helping him achieve his success in organized medicine. "I couldn't be here if it wasn't for their support. They cover for me and make sure my patients are taken care of; I think that is as much of a contribution to organized medicine as what I am doing."

Too often individuals look toward participating on a grand scale, when it's really all the little everyday things that have the most impact, Dr. Traugott noted. "When physicians do what is expected of them as professionals, we become recognized for that, for taking care of the needs of patients, and that truly is our agenda." ■

House victories

(Continued from page 3)

defeated on the floor, receiving only 51 of the necessary 60 votes. It was placed on postponed consideration but was not called for another vote before the deadline for House bills. An identical Senate bill, S.B. 228, sponsored by Sen. Karen Hasara (R-Springfield), lost April 23.

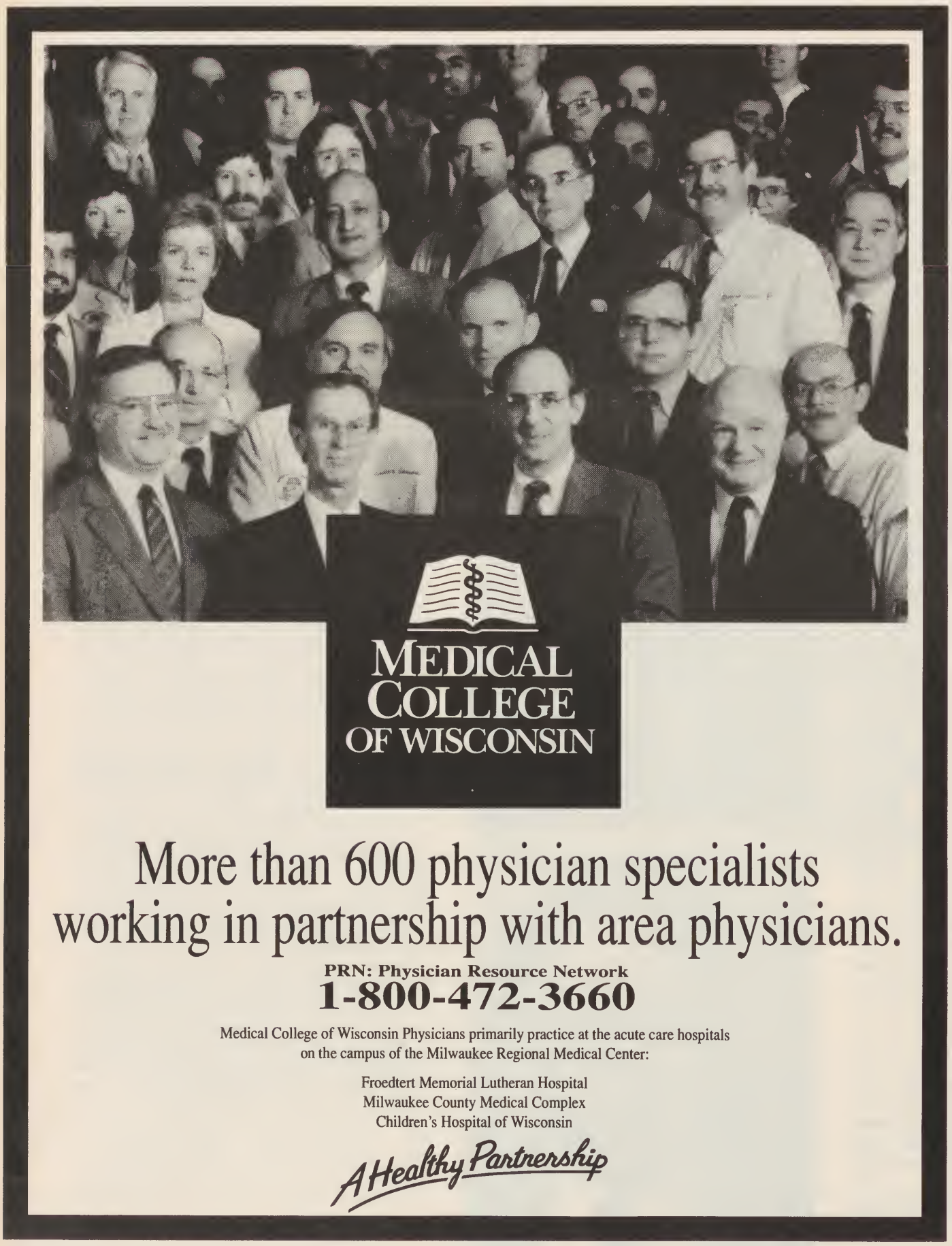
If H.B. 2048, sponsored by Rep. Carol Ronen (D-Chicago), had been allowed to advance, nurse practitioners would have been entitled to full public aid reimbursement as primary care providers. Under the original bill, certified nurse midwives and certified nurse practitioners would have been directly reimbursed by the Illinois Department of Public Aid at the same rate as physicians. The bill was amended to omit nurse midwives and reduce the reimbursement rate to 90 percent. ISMS opposed the bill because it would essentially allow nurse practitioners to act independently as physicians even though they lack the necessary medical training.

Mandatory assignment bills H.B. 1504 and H.B. 1505, sponsored by Rep. Jan Schakowsky (D-Evanston), also failed. H.B. 1504, which lost on third reading, would have required physicians to notify patients if they did not accept assignment of Medicare charges. It also called for double recovery if physicians failed to notify their patients. H.B. 1505 would have required hospitals to notify patients if physicians who provided elective surgery services did not accept Medicare assignment charges. The bill would have established a double-recovery provision.

A trial lawyer-backed bill that would have created the Sunshine in Litigation Act also lost on third reading. H.B. 1930, introduced by Lang, would have allowed public scrutiny of private documents filed in civil suits, including malpractice suits.

H.B. 1928, sponsored by Rep. Barbara Flynn Currie (D-Chicago), would have amended the Health Care Worker Self-Referral Act to accelerate physician compliance. In essence, the bill would have cut two years from the time frame for physicians to establish alternative referral patterns. The result could have been severe hardship for health care professionals attempting in good faith to comply with the law. The bill was referred back to committee.

An amendment to H.B. 793, which was filed but not considered, would have tripled licensure fees and denied physicians due process, among other onerous provisions. Schakowsky sponsored the original vehicle bill, which would have created a so-called Blood Safety Act; the bill had no substantial language. Had H.B. 793 been successfully amended, it would have become identical to another Schakowsky bill, H.B. 1503, which died earlier in the session. When the attempt to amend H.B. 793 failed, the vehicle bill stalled in the House. ■



ISMS-backed bills

(Continued from page 3)

Collins (D-Chicago), the measure bans any form of mandated birth control for individuals who have committed felonies or misdemeanors.

ISMS prompted the introduction of S.B. 602, which calls for the director of IDPR to receive complete information before acting on controlled substance licenses. The bill was sponsored in the Senate by Fitzgerald and in the House by Rep. Miguel Santiago (D-Chicago). S.B. 602 would amend the Illinois Controlled Substances Act to require IDPR to receive input from the appropriate licensure or disciplinary board before taking action against individuals holding controlled substance licenses. It was written to help ensure peer review and due process in disciplinary proceedings. The bill received unanimous support from the House Judiciary I Committee and passed on the House consent calendar by a vote of 116-0.

S.B. 603 would establish a $100 fee for individuals who renew their medical license within 12 months of its expiration date, ensuring that physicians would not have to pay the full fee if they were issued a license during the last year of the renewal cycle. The standard $300 fee would remain the same for all other renewals. The bill was originally sponsored by Fitzgerald and was introduced in the House by Rep. Frank Giglio (D-Calumet City). S.B. 603 advanced out of the Senate and was assigned to the House Registration and Regulation Committee, where it was held, based on a House leadership decision to hold all fees-related bills. ISMS and the sponsor then pushed for a motion to discharge from committee and put the bill before the entire House. This motion was adopted without a dissenting vote on the House floor, where the bill will now be considered.

S.B. 372 was placed on interim study. Rep. Judy Biggert (R-Westmont) sponsored the Senate bill when it moved to the House; earlier in the session, she had introduced an identical bill, H.B. 1972, which was also placed on interim study. The measure would have prohibited plaintiffs who had voluntarily dismissed a malpractice action and begun a new action in the same year from gaining a 90-day extension to file the required certificate of merit. ■



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Highlights of the 1993 ISMS Annual Meeting





Uncle Sam and IMPAC supporters (above, from left) Drs. Wayne N. Leimbach, Richard A. Geline, M. LeRoy Sprang, Alan M. Roman, Dennis M. Brown and Raymond A. Dieter Jr. asked physicians to "dig a little deeper" for the Liability Battle Fund. IMPAC raised nearly $6,000; all new IMPAC recruits (right) received "I enlisted" pins.



Newly installed ISMS President Arthur R. Traugott, MD, an Urbana psychiatrist, celebrates his election with his wife, Shirley, during the House of Delegates meeting. Dr. Traugott said he hopes to get more Illinois physicians involved in health care reform.

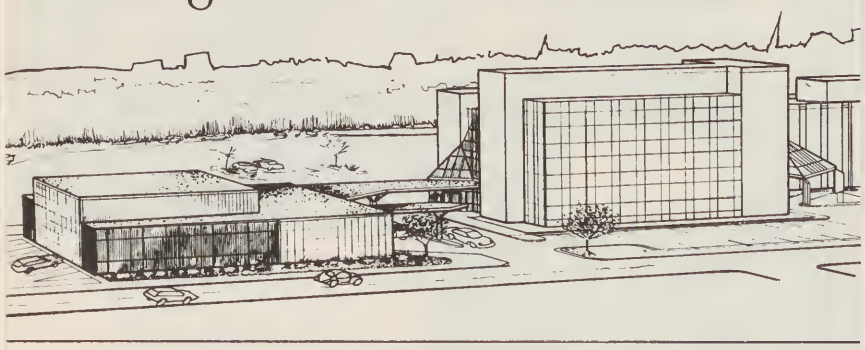




Fred Z. White, MD (top left), presents the 1993 Edwin S. Hamilton Interstate Teaching Award to Chicago internist Stuart Levin, MD. Meanwhile, David Lee Gorenz, MD (bottom left), a Peoria internist, and Johanna M. Lund, of Rockford, proudly display their 1993 ISMS Public Service Awards.

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Annual Meeting

(Continued from page 1)

Five reference committees heard testimony April 23 on a wide range of topics. Individual resolutions proposing changes to the current health care system were submitted, but, except for a resolution proposing exploration of the concept of medical Individual Retirement Accounts, none were adopted.

Billing Practices

Several other resolutions also dealt with billing practices. ISMS President-elect Alan M. Roman, MD, chairman of the Cook County delegation, submitted a resolution opposing mandated electronic Medicare claim submission. Reference committee discussion of this resolution centered on minimizing such federal mandates. Another resolution submitted by Dr. Roman called for physicians to be paid individually by third-party payers when patients are treated by several physicians. A third resolution endorsed reimbursement to physicians for their time while under review by third-party payers. All three billing resolutions were adopted.

Data Bank

Illinois physicians again expressed their concerns about the National Practitioner Data Bank by adopting a substitute resolution calling for ISMS to submit a resolution to the AMA demanding the "timely dissolution" of the Data Bank. Illinois delegates to the AMA have previously taken their fight against the Data Bank to the AMA House, but no national action has yet been adopted to achieve this desired result. To date, the AMA has been negotiating with federal officials to lessen some of the Data Bank's more onerous requirements. By adopting the substitute resolution, Illinois physician delegates solidified their resolve to hasten the Data Bank's demise.

CPT Codes

The trend toward using Current Procedural Terminology codes to report nonphysician services stirred heavy debate in reference committee. A resolution calling for CPT codes and descriptors to be used only to report physician services was submitted by Luis E. Cespedes, MD, a DuPage County delegate. The House adopted the resolution as amended, which included asking the AMA to ensure that CPT codes and descriptors be used as billing references for only MDs and DOs, not limited-license practitioners.

Drug Testing

Citing an American Hospital Association "management advisory" advocating drug testing of all physicians when they first apply for medical staff privileges, William P. Gibbons, MD, of DuPage County, submitted a resolution calling for ISMS to resist no-cause drug testing as part of credentialing processes. Although physician delegates listed reasons for supporting drug testing when sufficient cause exists, no testimony was heard in support of random drug testing. The House adopted the resolution with little debate. The new policy also states that physicians should be subjected to drug testing only if the hospital has "reasonable suspicion" and ensures substantive due process safeguards.

Economic Credentialing

Declaring economic credentialing a growing problem jeopardizing quality of care and physician autonomy, delegates supported resolutions addressing exclusive contracts, due process and administrative withdrawal of hospital privileges. Four resolutions were considered that called for ISMS to develop policy and introduce legislation preventing hospitals from using economic credentialing to determine medical staff appointments, reappointments and clinical privileges.

Submitted by ISMS President-elect Alan M. Roman, MD, chairman of the Cook County delegation, two of the four resolutions dealt with due process and the role of medical staff members regarding exclusive contracts. After hearing strong arguments supporting both resolutions, the reference committee recommended a single substitute resolution for adoption by the House. The substitute resolution called for development of ISMS policy to arm physician medical staff members with "a right, an obligation and a responsibility" to review nonmonetary aspects of proposed exclusive contracts between hospitals and physicians. It also endorsed introduction of state legislation protecting physicians' rights to due process. After extensive floor debate, the House adopted the substitute resolution. In addition, the House referred it for national action.

Resolutions submitted by Brian Miller, MD, of Sangamon County, and Raymond A. Dieter Jr., MD, of DuPage County, opposed exclusive contracts that violate medical staff bylaws. The House adopted a single substitute resolution calling for ISMS to develop a position paper on economic credentialing that addresses the "potential pitfalls" of changing medical staff bylaws and an opinion on the appropriate use of exclusive contracts. The newly adopted resolution urges the Society to introduce legislation in "as timely a fashion as possible" amending the state's Hospital Licensing Act to require that due process procedures are followed when physicians apply for initial medical staff privileges and re-credentialing.

Wm. Daniels/The Photo Partners



Stephen R. Kappel, MD, a St. Clair County delegate, debates on the House floor.

Unanimously supported in reference committee, a resolution concerning hospital governing boards was readily adopted by the House. Submitted by Charles G. Pogue, MD, a delegate for the Hospital Medical Staff Section from Rock Island County, the resolution directs the Society to develop policy stating that medical staff should be included as voting members on hospital governing boards and action committees. This policy should be distributed "in an appropriate manner" to the Illinois Hospital Association and to all hospitals in Illinois, the delegates said.

Medical IRAs

Favorable testimony in reference committee prompted the adoption of a resolution – submitted by Albert W. Ray Jr., MD, of Joliet – to explore financing health care with medical IRAs. Such tax-free or tax-deferred accounts should encourage patients to seek cost-effective care and would allow them freedom of choice in using medical IRA funds. The funds would be garnered from a combination of sources, including patients, employers and the government.

Resident Physician Seat on ISMS Board

A resolution proposing a resident physician seat on the ISMS Board of Trustees sparked lively discussion in reference committee and the House of Delegates. Introduced by Hilary B. Kern, MD, the delegate for the Resident Physicians Section, the resolution called for the seat to include voting privileges.

Resolution proponents maintained residents would contribute a different perspective to the board and their participation would provide experience in organized medicine. In addition, proponents said several other state medical societies and the AMA currently slot resident physicians seats on their boards.

Opponents said that if resident physicians were given a seat, other groups might want representation. This might change the board's geographic balance and decrease members' overall experience level. They also expressed concern about the learning curve, saying that by the time resident physicians learned the issues and the workings of the board, their term would end. Consequently, the resolution was amended to provide for the seat but without voting privileges.

The amended resolution passed and will become effective if the House of Delegates approves the necessary bylaw changes at the 1994 Annual Meeting.

Rural Health

A resolution urging the state of Illinois to fund the Rural/Downstate Health Act drew only favorable testimony in reference committee and was swiftly adopted by the House. Submitted by John H. Texter, MD, of Sangamon County, the resolution refers to the rural health initiative developed by the ISMS Health Care Access Committee and the Southern Illinois University School of Medicine. Although the Illinois legislature incorporated the principles of that initiative into the Act, lawmakers have failed to provide funding to get the program off the ground.

Another resolution addressing access and the shortage of primary care physicians, was submitted by Norman J. Scheibling, MD, of Sangamon County. The resolution asked ISMS to seek solutions, including legislation, to alleviate the shortage of primary care physicians in Illinois. Reference committee discussion disclosed current legislative activity on the issue, and given the implications for health care reform, most physicians agreed that the issue should be part of ISMS' overall discussion on reform. The House followed the reference committee's recommendation and referred the resolution to the Board of Trustees for decision.

Utilization Review

The trend toward out-of-state utilization reviewers looking over physicians' shoulders was the impetus for a resolution introduced by Ronald D. Frus, MD, a delegate for the Rock Island County Medical Society. Reference committee testimony unanimously supported the resolution, which called for physicians who are employed by third-party payers and who perform reviews in Illinois to have an Illinois medical license. Delegates adopted the resolution with only editorial amendments.

Physician delegates criticized the way reviews and pre-admission certifications are often conducted: over the phone by an unknown reviewer in another state. Even though some of these reviewers may be physicians, they are making decisions about patient care for Illinois residents without holding an Illinois medical license, delegates said. The House policy directs ISMS to require – either through regulation or legislation – all physicians authorizing or reviewing the care of Illinois patients to be licensed in the state to practice medicine in all its branches. Existing Society policy had already supported this concept and stated that ISMS is opposed to utilization review conducted by phone with no recourse for physicians to be reviewed by MDs or DOs in their same state who practice in the same specialty. ■

Watch for more Annual Meeting coverage in the next issue of Illinois Medicine.

AMA perspective

(Continued from page 4)

Dr. Scalettar did express concern, however, about some of the vague terms used by the Clinton administration as the plan's scheduled announcement date approaches. The unveiling, which was scheduled for May, was pushed back once because of the illness and death of First Lady Hillary Rodham Clinton's father, and a second time to give the administration time to muster congressional support.

Physicians have remained firm about the kind of reform they want to see, Dr. Scalettar said. "No system will work unless it includes the patient's freedom to choose."

However, Dr. Scalettar said he fears the administration may develop a cost-driven plan, rather than one based on quality. "They want only what will work quickly and politically.

"Each serious health problem carries an enormous price tag, and doctors are still catching the blame," he continued. "Unless we respond, [misperceptions] get perceived as fact. It's easier to blame us than to dig into the real causes. Since antiquity, physicians have been powerful symbols for healing. Most patients say their doctor is the most trustworthy person they know. The medical profession is not part of the problem, but at the heart of the solution."

Dr. Scalettar suggested that if physicians feel excluded from the reform debate because of media accounts of the task force's machinations, they shouldn't believe everything they hear. "Reform won't work without us. There's nothing we won't put on the table. We won't accept anything that puts a cap on care." ■

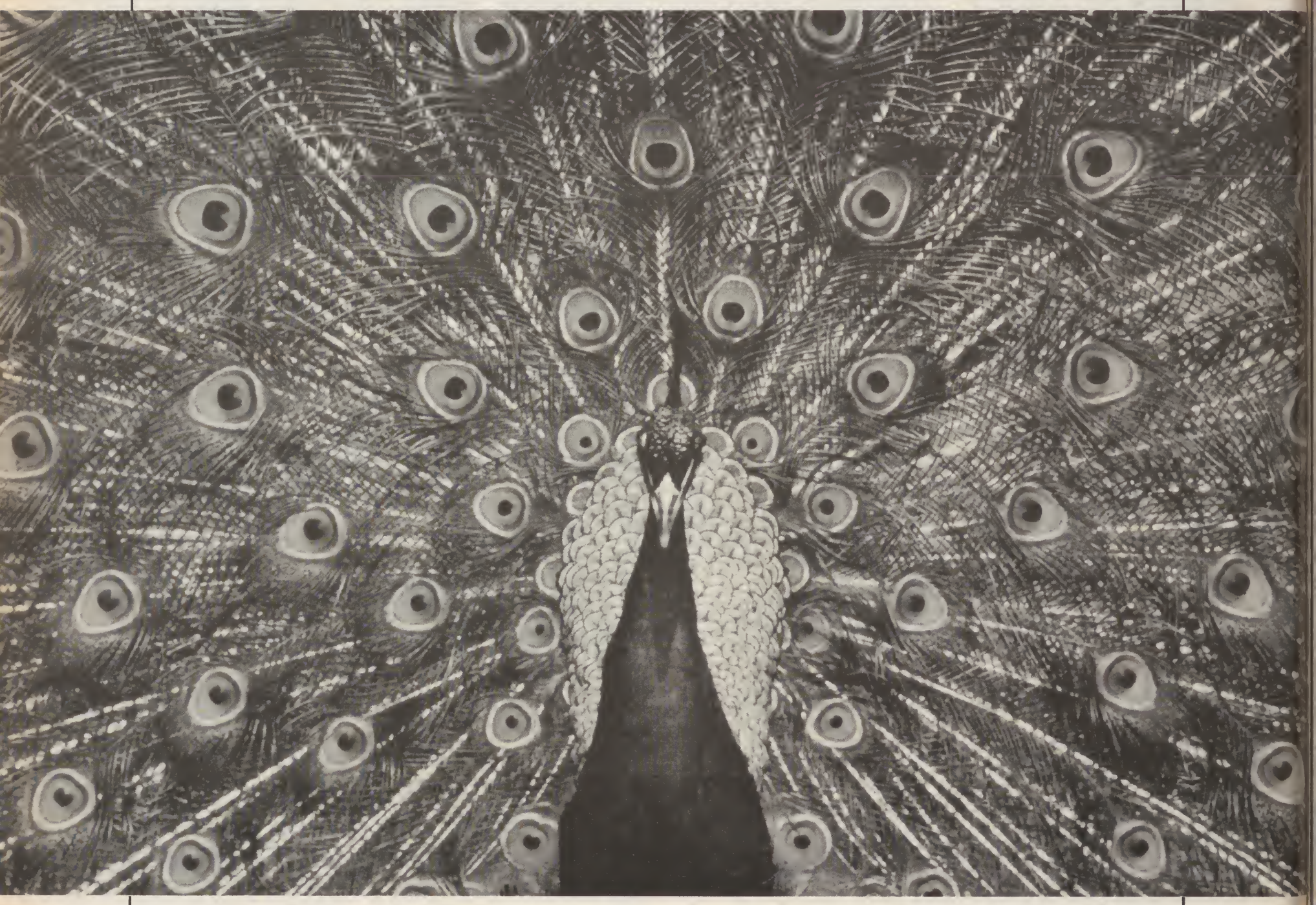
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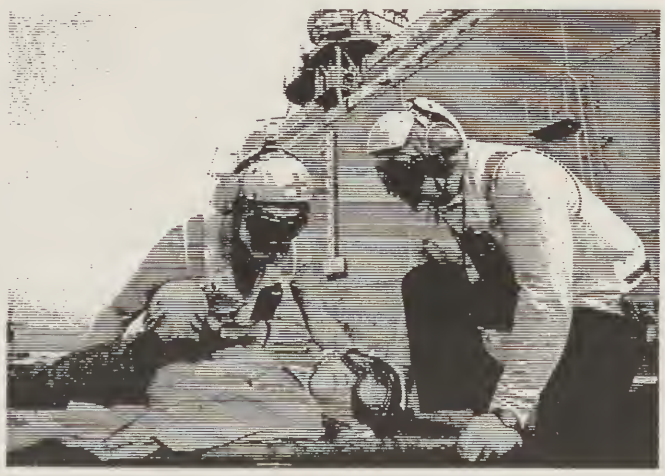
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Caps

(Continued from page 1)

couraging, Dr. Traugott said, because last-minute replacement of key committee members led to the adoption of a "do not pass" motion, effectively ending the bill's run for this year.

Dr. Traugott had hoped to persuade committee Democrats to help advance the bill by testifying that a cap would increase access to care and bring fairness to the justice system. "A cap would help juries do their job effectively and fairly," Dr. Traugott told the committee. "It would alleviate access problems while ensuring the availability of compensation for truly injured patients.

"ISMS wants fairness and justice," he continued. "The civil justice system is out of balance and is eroding access to care throughout the state. We must address the malpractice environment."

IN SPITE OF the House defeat, this is the first time caps on noneconomic damages have passed any house since ISMS first started pushing the measure in 1984 – a precedent that should continue into the foreseeable future, Dr. Traugott said.

Numerous witness slips indicating supporters and opponents of the bill were submitted to the committee. Pat Salvi, president-elect of the Illinois Trial Lawyers Association and brother of Rep. Al Salvi (R-Wauconda), and Thomas G. Salvi, MD, testified in opposition to the bill, claiming that any caps legislation would restrict the rights of the catastrophically injured. Salvi introduced a disabled man who had suffered a work-related injury. The man asked the committee how $250,000 could compensate for his losses. He failed to note, however, that economic recoveries would not have been affected under the legislation; all injured individuals would have retained their rights to be fully compensated for quantifiable losses.

During the debate, certain committee members wondered whether any amount of money could compensate the catastrophically injured. "The real issue is predictability in losses," said Rep. Ron Stephens (R-O'Fallon). "It's a tough issue, but the real issue isn't about [whether a plaintiff receives] $20 a day or $2 million dollars a day. Would that make a difference? I think not."

"It's easy to look at the bill in a microcosm," Dr. Traugott said in closing his testimony. "But this bill is a step in the right direction to controlling health care costs."

After hearing testimony on both sides of the issue, the committee voted 7-5 not to pass the bill. Despite the temporary setback, Dr. Traugott said the issue is far from dead and physicians will continue to support such tort reform measures. He asked that Illinois physicians thank their senators and representatives who support a cap of $250,000 for noneconomic losses. In addition, he noted that the 1994 elections provide physicians the opportunity to oppose those legislators who failed to support this bill and other measures that would have benefited patient care. ■

Roll call for S.B. 344

The following list shows how members of the House Judiciary I Committee voted on a "do not pass" motion on ISMS-backed caps legislation.

Biggert (R-Westmont)	No	Lang (D-Skokie)	Yes
Blagojevich (D-Chicago)	Yes	Levin (D-Chicago)	Yes
Cross (R-Yorkville)	No	Lawfer (R-Freeport)	No
Dart (D-Chicago)	Yes	Phelan (D-Chicago)	Yes
Hoffman (D-Collinsville)	Yes	Rutherford (R-Pontiac)	No
Kaszak (D-Chicago)	Yes	Stephens (R-O'Fallon)	No

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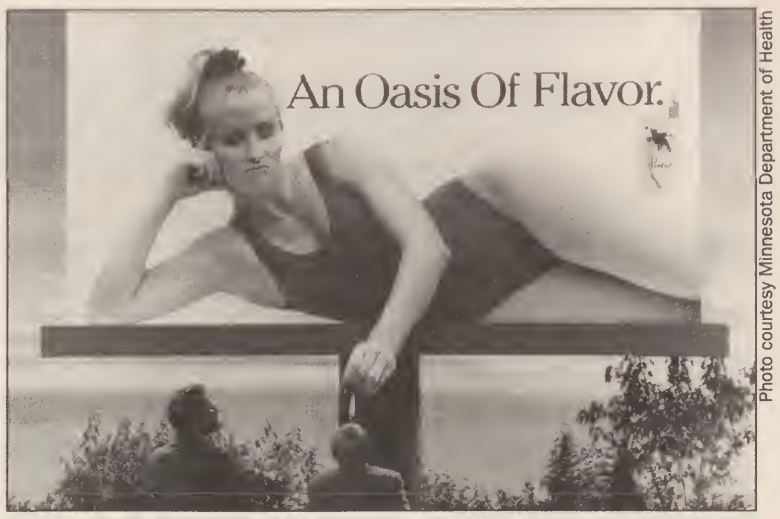


Photo courtesy Minnesota Department of Health

ONE OF THE CAMPAIGN public service announcements (right) features two male tobacco company executives admiring a billboard of a bathing suit-clad woman lounging with a cigarette. Suddenly the billboard comes to life, and the woman extinguishes her cigarette on the face of one of the executives. The other spot shows a billboard of three glamorous women smoking beneath the slogan "Women are making the rush to rich flavor." As the commercial closes, several letters on the billboard are covered, leaving behind the new phrase, "Women are making us rich."

Anti-smoking campaign

(Continued from page 1)

suade women that smoking is healthy and carefree," said Kustra, the state's anti-drug abuse czar, in announcing the program. "We must be as aggressive as the tobacco industry is with its advertising efforts, and we must launch public service campaigns to provide everyone with the facts about the dangers of tobacco."

The two "hard hitting" spots were produced by the Minnesota Department of Public Health, using funds obtained from sin taxes on cigarette sales, Kustra said.

"Tobacco companies spend nearly $4 billion every year to peddle this addictive and often lethal drug," Kustra said, adding that in the face of declining cigarette sales, the industry is targeting women, African-Americans and teenagers. "Given the amount of money that tobacco companies spend to market their products to women, it is no surprise that an estimated 2,000 young women begin smoking every day in the United States."

ILLINOIS WILL USE the program to try to influence the slow decline in the rate of smoking among women in the state, according to IDPH. Currently, there are more women smokers than men smokers in Illinois. Statistics show smoking rates among Illinois men dropped from 27.8 percent in 1988 to 23 percent in 1991, but among women the rate only dropped from 26 percent in 1988 to 24.1 percent in 1991.

"It was not long ago that smoking was thought to be sophisticated and glamorous," said IDPH Director John R. Lumpkin, MD. "But as a society, we have learned there is nothing sophisticated or glamorous about the tragic results of smoking – lung cancer, heart disease and emphysema. More than 7,000 women die each year in Illinois due to smoking-related illness. In addition to affecting their own health, women who smoke during pregnancy are endangering their child and are more likely to have miscarriages or give birth to dangerously small babies." Dr. Lumpkin said about $450 million is spent on health care services delivered to Illinois women for smoking-related illnesses or conditions.

Because of the state's continuing fiscal hard times, Kustra contacted the Minnesota health department and arranged for Illinois to borrow the PSAs. "We don't have the type of budget that California and Minnesota do for producing public health initiatives," said Tom Schafer, IDPH spokesperson. "Both of those states have a high tax on cigarettes, part of which is used for pricey educational campaigns like these."

ISMS policy also supports educational anti-smoking efforts, as well as legislative action to prohibit smoking in public places, including open and enclosed stadiums. The Society strongly endorsed H.B. 1576, which passed both houses. If signed, the bill would impose restrictions and prohibitions on tobacco sales to prevent children from smoking or chewing tobacco. The bill was sponsored in the House by Rep. John Dunn (D-Decatur); Sen. Doris Karpiel (R-Roselle) signed on as the Senate sponsor. Other ISMS-backed anti-tobacco measures failed to advance this session. ■

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(Continued from page 1)

supervision of a physician licensed to practice medicine in all its branches. "Our current policy works to preserve teamwork for our patients' benefit, with each component practicing its own special skills," said Arvind K. Goyal, MD, ISMS immediate past president.

In fact, the federal government mandates that nurse specialists be directly reimbursed for services only when those services are allowed by state law. Last year, HCFA asked the state of Illinois for an opinion on whether the state would allow for nurse specialists' independent practice. That opinion is a prerequisite for the federal government to allow direct Medicare and Medicaid reimbursement to nurse specialists.

> *An integrated team approach – rather than one of isolated, fragmented health care by individuals independent of one another – best serves the patient's needs.*

IDPA has forwarded an opinion by Nikki M. Zollar, director of the Illinois Department of Professional Regulation, to HCFA. The opinion compares Section 3 of the Illinois Nursing Act of 1987 with Section 49 of the Medical Practice Act, which "provides a strong indication that a nurse specializing in a particular practice area, even though he or she may have advanced education or training, may not diagnose any ailment or condition, nor prescribe medications to treat an ailment or condition."

The opinion also states: "These elements [diagnosing and prescribing] appear to be essential to 'independent' practice by a nurse specialist. In fact, under the Clinical Laboratory Act, only a licensed physician, licensed dentist, licensed podiatrist, authorized law enforcement agency or authorized individual may even order test results from a licensed clinical laboratory. The inability to order tests necessary for diagnosis or confirmation of diagnoses must, by definition, therefore severely hamper any attempt to practice 'independently.'"

In addition, the opinion points out that the Dental Practice Act and the Podiatric Medical Practice Act expressly grant authority to diagnose and prescribe for certain conditions. And the Controlled Substances Act stipulates that only physicians, podiatrists, dentists and veterinarians can prescribe controlled substances. Zollar concluded that because the Nursing Act does not address these issues, it seems the legislature did not intend to grant this scope of activity to nurses and nurse specialists.

The court has reinforced that opinion. Specifically, in *Gill vs. Foster*, the appellate court stated: "While nurses clearly have a different duty of care to a patient than does a doctor, and nurses do not diagnose patients' maladies or practice medicine, ... they, too, have a duty to note and report their observations." The key is the recognition that nurses do not diagnose patients' maladies or practice medicine.

Beyond the legal considerations is the potential liability problem. If nurse specialists receive direct reimbursement, that in itself might cause a chain reaction of greater independence, less physician supervision and more physician liability, according to risk management experts.

"An integrated team approach – rather than one of isolated, fragmented health care by individuals independent of one another – best serves the patient's needs," Dr. Goyal said. And providing the best patient care is what medical practice is all about. ■

Award winners

(Continued from page 8)

president's tour and said he had seen them "work beyond the call of duty more than once."

"Field services reflects teamwork because we link doctors to you," Gragert told ISMS employees as he accepted the award. "I would like to thank everyone who has helped me." He also noted the efforts of former Employee of the Month award winner Becky Prochnow, field services secretary. "Without her help we would look more like Abbott and Costello."

"It is a tremendous privilege and honor to receive this award," Gallagher noted. "I'm especially grateful for the help I've received from county medical society executives and other ISMS staff members."

All permanent, full-time ISMS employees, with the exception of senior management, are eligible for the Employee of the Month award. Physicians may nominate a staff member by calling the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■



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Illinois Medicine

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Auxiliary Annual Meeting highlights
PAGE 17



Responding to seniors' special needs
PAGE 12

Bills advance at session's end

LEGISLATION ROUNDUP: ISMS achieved many successes during the shortened legislative season. By Anna Brown

[SPRINGFIELD] Entering the final weeks of the legislative session, a variety of health care-related bills had passed both houses and were either waiting for the governor's signature or House and Senate concurrence on new amendments.

The Illinois General Assembly finished most of its business about a month earlier than its usual June 30 adjournment, acting on about 270 bills of primary interest to medicine. Of the 168 House bills on ISMS' primary list, 53 advanced to the Senate, with 29 of them ultimately stalling in Senate committees. Twenty-six of the 103 Senate bills of primary interest to ISMS reached the House, with two remaining in committee. ISMS scored legislative victories by successfully advancing key measures and by blocking Society-opposed proposals.

Half of the 15 primary bills introduced on behalf of ISMS were still alive near the end of the session. To date, ISMS prompted the introduction of five bills that passed both houses, and three others were awaiting third reading.

A SIGNIFICANT SUCCESS for Illinois physicians was the passage of both House and Senate versions of a bill prohibiting stays of disciplinary actions under certain conditions. Following the 116-0 vote on S.B. 601 in the House, H.B. 1971 passed the Senate on May 17. S.B. 601 was sponsored by Sen. Peter Fitzgerald (R-Palatine) and Rep. Bob Biggins (R-Elmhurst). Fitzgerald also sponsored the House bill in the Senate, which was originally introduced by Rep. Joseph Kotlarz Jr. (D-Chicago). The bills were introduced at the Society's request after a recent Illinois Supreme Court ruling allowing dentists to continue practicing until all Illinois Department of Professional Regulation disciplinary actions against them are resolved. The bills would allow physicians to continue practicing only if a court stayed the disciplinary action based on evidence demonstrating that the physician would not be a danger to the public.

The director of IDPR must receive complete peer-reviewed information before acting on controlled substance licenses if S.B. 602 is signed into law. The bill, sponsored by Fitzgerald and Rep. Miguel

(Continued on page 21)

INSIDE

Illinois MDs honored by HHS
PAGE 3



P. John Seward, MD: Focusing on physician constituents
PAGE 15

DEPARTMENTS

News Briefs.....2

Commentary.....6

ISMIE Update 9

On the Business Side 18

Classifieds 19

Members in the News.....23



Wm. Daniels/The Photo Partners

U.S. REP. J. DENNIS HASTERT (center), pictured with Phillip Jacobson, MD (left), and Julius Newman, MD (right), spoke May 17 at Copley Memorial Hospital in Aurora. Hastert represents House Republicans on the White House health care reform task force.

Healthy Moms/Healthy Kids program receives ISMS support

MEDICAID: ISMS approves IDPA's program and is working to resolve questions. By Gina Kimmey

[CHICAGO] For the first time since its inception, the Illinois Department of Public Aid's Healthy Moms/Healthy Kids program is receiving ISMS support. The Board of Trustees' endorsement was made April 25 during the ISMS Annual Meeting in Oak Brook.

"We are reasonably comfortable with the program's development," said ISMS President Arthur R. Traugott, MD. "Many details still need to be worked out, but we are monitoring the progress and continue to work closely with IDPA."

HMHK program enrollment was slated to begin May 24 and will be phased in over several months. But the proposed phase-in schedule for enrolling patients has changed numerous times, Dr. Traugott said. Currently, IDPA plans to start with

(Continued on page 5)

Economic credentialing

Providing due process in hospitals' economic credentialing practices topped the legislative agenda for physicians as the season drew to a close. Watch for more coverage in upcoming issues of *Illinois Medicine* to learn the outcome of this and other issues affecting medical practice.

ISMS BEHIND THE SCENES

PROGRAM TARGETS RURAL ACCESS TO HEALTH CARE

For more than 40 years, ISMS and the Illinois Agricultural Association have worked together to improve health care access in rural communities throughout Illinois. In 1947, after recognizing the decreasing number of physicians serving rural areas, ISMS and IAA formed the Student Loan Fund and elected a six-member board to oversee the program and recommend three students for admission to the University of Illinois College of Medicine. The first three were selected in 1948. Selected students were offered up to $2,500 in student loans. In exchange for a recommendation, a loan, or both, the student agreed to practice in a primary care specialty and spend at least five years serving a rural community.

To date, the program – renamed the Rural Illinois Medical Student Assistance Program (RIMSAP) – has recommended more than 700 physicians to the medical school. The

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Parental notification bill defeated

H.B. 1300: A bill died May 26 that would have imposed extreme civil penalties on physicians who violated provisions to notify minors' parents when performing abortions. By Anna Brown

[SPRINGFIELD] Illinois physicians were relieved of the specter of hefty fines, civil suits and disciplinary action when H.B. 1300, the bill regarding parental notification of minors' abortions, fell seven votes short of passage in the Illinois House of Representatives May 26. ISMS opposed the bill, sponsored by Rep. Terry Parke (R-Schaumburg) and Sen. Thomas McCracken Jr. (R-Westmont), solely because of provisions that would have created three levels of penalties. ISMS had suggested alternative language for the penalties section of the bill, which would have removed the Society's opposition to the legislation.

> *Extreme civil penalties that undermine the physician's sound medical judgment could destroy the benefits that patient counseling and parental consent are designed to achieve.*

"Our physician members have a variety of individual and often divergent viewpoints on the issue of abortion," said ISMS President Arthur R. Traugott, MD. "In this we are no different than society as a whole. But our role is to give the best medical care possible to our patients – not to take sides on the abortion debate. Civil penalties would subject physicians to the whims of pre-election political posturing by states' attorneys and other political candidates at the expense of the doctor's judgment and the patient's best interest."

Penalties against physicians would have included a mandatory fine of $1,000 for failure to verify that parents had been notified 48 hours before performing an abortion on a minor. The fine would have been raised to $5,000 for each additional offense. The bill also provided that any state's attorney or the attorney general could bring civil actions against physicians who failed to provide parental notice. This policy would have been in addition to civil penalties imposed by the Illinois Department of Professional Regulation Medical Disciplinary Board. Current Illinois law requires that lack of compliance cases, such as child abuse reporting, be referred to the Medical Disciplinary Board.

"In all other circumstances, physicians undergo scrutiny by their peers to measure their clinical and ethical practices," Dr. Traugott said. "Illinois' medical profession has worked hard to build strong medical licensure laws to prevent unqualified or unethical medical practice."

Dr. Traugott explained that the Medical Disciplinary Board already has the power to impose penalties of up to $5,000, and to limit, restrict and revoke licenses. In addition, informed consent lawsuits against physician defendants could result in significant monetary damages awarded as a result of malpractice litigation. "The bill should have stipulated that willful violations of the Parental Notification Act should be referred to the Medical Disciplinary Board for appropriate discipline," he said.

"Doctors routinely notify parents to obtain consent when treating minors for any medical condition," Dr. Traugott continued. "Physicians do indeed counsel their teenage patients to talk to their parents about personal health care issues. But extreme civil penalties that undermine the physician's sound medical judgment could destroy the benefits that patient counseling and parental consent are designed to achieve."

Originally, H.B. 1300 passed the House, but bill supporters under pressure to move the measure through the Senate, fearing a veto from Gov. Jim Edgar, agreed to compromise language that would allow women under age 18 who seek an abortion to notify a judge instead of their parents, 48 hours before the procedure. House concurrence with the Senate amendment would have sent the bill to the governor's desk. ■

Two Midwest Blues plans may combine

[CHICAGO] On May 26, two Blue Cross and Blue Shield plans covering Illinois, Iowa and South Dakota announced their intention to combine their operations into a single entity. Under the proposal, Health Care Service Corporation, Blue Cross and Blue Shield of Illinois' corporate identity, and IASD Health Services Corporation of Iowa, which includes Blue Cross and Blue Shield of Iowa and Blue Cross of South Dakota, would provide health care coverage to more than 3.6 million people. The united entity would carry reserves of $740 million.

"By combining our capabilities, we will be better able to achieve our common mission of assuring as many citizens as possible access to affordable, quality health care," said Raymond F. McCaskey, president and CEO of Health Care Service Corporation.

Before the proposed union can proceed, it must still be approved by the state insurance regulators of Illinois and Iowa, and must be reviewed by regulators in South Dakota. The boards of both companies have signed a nonbinding memorandum of intent to combine their operations. Details of the final agreement are being determined and will be released when available, according to a May 26 Blue Cross and Blue Shield of Illinois press release.

According to the release, the new entity will achieve cost efficiencies through economies of scale and by sharing systems and information. The plans would retain their individual operations and locations for the foreseeable future, and a unified board of directors would be appointed in 1994.

"As we enter an era of far-reaching reform in our nation's health care system, the new corporation, because of its strength, would be in a far better position than either corporation alone to face future challenges and shape a secure destiny," said Robert D. Ray, president and CEO of IASD Health Services Corporation and former Iowa governor.

"Our customers will be foremost in our planning," Ray continued. "They will see no change in the way they receive service as we move toward joining these companies. Over the long term, our ultimate goal is to use this union to provide the best possible service to our customers in the most efficient way." ■

Clinton waters down vaccine program

[WASHINGTON] Under pressure to set health care and political priorities, President Clinton agreed to scale down a proposal that would have provided free vaccinations to U.S. children. The new proposal still incorporates certain health services, such as educating parents, improving vaccination records, extending public clinic hours and hiring public nurses. But under the amended plan, only children enrolled in Medicaid and those whose insurance does not cover immunizations would be eligible for free vaccinations.

According to press reports, the proposal was revised because drug companies and Republicans in Congress were concerned that the federal government would fund vaccinations for children whose parents could afford to pay for them. Even after the revision, however, several drug companies criticized the watered-down version, saying the program still advocates universal vaccine buying, which eliminates market competition for these products. Currently, only half of all private insurance plans cover vaccinations; the president's proposal would not require insurers to continue providing such benefits.

Some are calling the president's retreat on the immunization plan the latest setback for the administration's health care reform package, which was to be unveiled in May. The death of first lady Hillary Rodham Clinton's father and attempts to garner greater support on Capitol Hill have delayed announcement of the plan. The *Washington Times* reported that Clinton may announce the package in two stages, by presenting a white paper this spring and introducing specific legislation later in the year. ■

PHYSICIAN FACTS

The impact of nosocomial infections

Nosocomial infections – infections originating in a hospital – lead to higher health care costs, extended hospital visits and, in some cases, death.

Type of infection	Deaths caused directly by infections	Deaths to which infections contributed	Extra hospital days per infection	Extra charges per infection
Lower respiratory tract	7,087	22,983	5.9	$5,683
Bloodstream	4,496	8,844	7.4	3,517
Surgical wound	3,251	9,726	7.3	3,152
Urinary tract	947	6,503	1.0	680
Other types	3,246	10,036	4.8	1,617
All types	19,027	58,092	4.0	2,100

Source: *Morbidity & Mortality Weekly Report*; U.S. Centers for Disease Control and Prevention, 1992

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ISMS and IHA to co-sponsor reform program

[CHICAGO] ISMS and the Illinois Hospital Association will co-sponsor the program "Physician/Hospital Collaboration Models in an Era of Health Care Reform" July 22. The focus will be the relationships of hospital medical staff and hospitals in a managed care environment and the possible effects of the Clinton plan on these relationships. The program, which is targeted at chiefs of medical staffs, HMSS representatives, and hospital CEOs and board chairmen, will be held at the Drake Oak Brook Hotel from 8:15 a.m. to 5 p.m.

Speakers will include Jeff Goldsmith, national adviser to Ernst & Young and president of Health Futures Inc.; William G. Plested, MD, past president of the California Medical Society; and Lee McCormick, MD, chairman of the AMA's Hospital Medical Staff Section.

Luncheon and a cocktail reception from 5 p.m. to 6 p.m. are included in the $150 registration fee. For more information, see the next issue of *Illinois Medicine*. ■

Department seeks medical director

[SPRINGFIELD] The Illinois Department of Children and Family Services is seeking a pediatrician or family physician for the position of medical director. The position is half-time and contractual, and may be based in Chicago or Springfield, although Springfield is preferred.

The medical director oversees the department's policies, procedures and services, which provide timely access to quality health care services for children placed in substitute care. Responsibilities include working with the staff of the department's Health Services Unit and with regional staff, including 30 nurses, statewide.

Inquiries and applications should be made to the director, Department of Children and Family Services, 406 East Monroe, Springfield, IL 62701-1498. ■

FDA orders contraception labels

[WASHINGTON] New contraceptive labels specifying whether certain birth control methods reduce the risk of STDs and HIV infection should be placed on product packages by October, according to U.S. Food and Drug Administration officials.

As reported in *USA Today*, the FDA commissioner's special assistant for women's health called the spread of STDs and the role of contraceptives confusing to young people.

Only latex condoms will bear labels stating their effectiveness in protecting against STDs. Labels on packaging for all oral contraceptives, implants, injectables, IUDs and natural skin condoms will explain that these products offer no protection against disease. Because of conflicting evidence about their role in reducing STD risk, spermicides, cervical caps, diaphragms and a brand-name sponge will not be required to carry such labels. ■

Illinois MDs honored by HHS

SERVICE: Community health promotion efforts of Illinois groups are rewarded by HHS Secretary Donna Shalala. By Gina Kimmey

[SPRINGFIELD] The federal government has recognized the efforts of two Illinois physicians and five projects to promote good health throughout Illinois communities. Selected by HHS Secretary Donna Shalala, the recipients were honored at award ceremonies May 18 in Springfield and May 19 in Chicago. State health director John R. Lumpkin, MD, presented the biannual awards.

Jack L. Bailen, MD, a retired pediatrician from Bloomington, received the Secretary's Community Leadership Award for his work providing basic medical care to indigent children in his community. His involvement as an advocate for increased health care access for children began more than 40 years ago and continues today through the free clinic he still operates three times each week.

(Continued on page 22)



Ron Ackerman

Dr. Lumpkin presents Dr. Bailen with his award in Springfield.

Blue Cross Blue Shield

REPORT FOR *Illinois Physicians*

MEDICARE INCREASES ACTIVITIES IN CONTROLLING FRAUD AND ABUSE

Section 1862(a)(1)(A) of the Social Security Act excludes from Medicare coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Continued fraudulent and abusive billing for non-covered services - involving at least 10 percent of the cost of Medicare - has led the Health Care Financing Administration (HCFA) to reiterate its concern for fraud and abuse. HCFA has established a network for carriers across the nation to share fraud and abuse information amongst themselves and Peer Review Organizations (PROs). Selected carriers - including Blue Cross Blue Shield of Illinois - now have Medicare Fraud and Abuse Coordinators (MFAICs) to coordinate fraud an abuse information, and to educate beneficiaries, physicians, suppliers and others about fraud and abuse.

Fraud and abuse issues of concern to this carrier involve:

Physicians

- billing for services that are not performed, unnecessary (not medically indicated or medically indicated but excessive), or incorrectly coded (wrong code used, upcoded, unbundled)
- certifying medical necessity irresponsibly

Physiological Laboratories

- billing for tests and test batteries that are ordered inappropriately, not ordered, not performed, substandard (conducted by unqualified personnel or with inappropriate equipment), or interpreted by unqualified personnel

Suppliers

- soliciting nursing facilities to order (including having physicians certify medical necessity) DME items that are unnecessary or inappropriate
- billing for upcoded or substituted DME items
- billing for DME items that are not provided

Nursing and Retirement Facilities

- releasing residents' Health Insurance Claim Numbers (HICNs) irresponsibly
- acquiring certifications of medical necessity after medical services are ordered or rendered, or DME items are ordered and provided

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(Issue: 06/04/93 - MedB)



Dr. Stockdale won the first ISMS Public Service Award for caring for indigent patients.

County medical society improves access

REFERRAL: Rock Island County physicians are supporting a network dedicated to assuring indigent residents of adequate medical care. By Gina Kimmey

[ROCK ISLAND] The physicians of Rock Island County have taken to heart the need to improve health care access. Through the continued use of the county's Physician Referral Systems, area doctors work to ensure that indigent residents have access to proper medical care. According to the Rock Island County Medical Society, member physicians provided more than $6 million in "free" care to public aid recipients during the past fiscal year.

The inspiration for the referral systems originated with Earl M. Stockdale, MD, a retired Rock Island pediatrician. Dr. Stockdale first suggested a rotating referral system in the late 1970s when he learned the community would receive an influx of refugees from Southeast Asia. Since its inception in 1977, the OB referral system has helped 11,022 pregnant women find obstetricians for prenatal care and delivery. The county's primary care referral service has found physicians for 14,743 indigent patients since its 1980 start-up.

"We are pleased and proud that the physicians of Rock Island County continue to participate in our Physician Referral Systems to assure the indigent of access to care," said J.H. Gardner, MD, Rock Island County Medical Society president. County physicians are also providing an increasing amount of free care by treating area Medicaid recipients, Dr. Gardner said.

According to IDPA figures, Rock Island health care providers were reimbursed for $38.4 million in health services delivered to Medicaid patients during fiscal 1992. Of that total, IDPA paid $13.8 million to nursing homes, $12.3 million to hospitals, $4.2 million to physicians, $4 million to pharmacies and $4.1 million to other providers.

Since its inception in 1977, the OB referral system has helped 11,022 pregnant women find obstetricians. The county's primary care referral service has found physicians for 14,743 indigent patients since its 1980 start-up.

But the department's reimbursement rate for physicians represents only about 40 percent of customary charges, Dr. Gardner said, which means county physicians provided $6.4 million in unreimbursed care to public aid patients between July 1991 and June 1992. "That figure does not include unreimbursed services to the unemployed, underemployed or others who do not qualify for public aid," he added.

Winner of the first ISMS Public Service Award in 1987, Dr. Stockdale was lauded for his untiring advocacy for the public health and his dedication to providing quality care for indigent patients through the creation of the referral systems. Although Dr. Stockdale has since retired, the physicians of Rock Island County have kept the system going strong, according to the medical society.

"When United Way fell short of its campaign goal last fall, the referral systems lost their administrative funding, but the [Rock Island County] medical society auxiliary stepped in with funding to keep the system alive," Dr. Gardner said.

Physicians interested in learning more about Physician Referral Systems can contact the Rock Island County Medical Society in Davenport, Iowa, at (319) 323-1916. ■



Healthy Moms

(Continued from page 1)

the 9,500 public aid patients participating in the Families with a Future program, followed by new IDPA applicants and pregnant women not in Families with a Future. Some new applicants will also be phased in. According to the department, other IDPA recipients will not be enrolled until at least late August or September.

Downstate and Chicago physicians participating in HMHK will receive the higher reimbursement rates offered under the program as soon as their applications to participate in HMHK are received by IDPA. When patients are formally assigned to their practice, physicians treating Chicago recipients will also receive the $5-per-month-per-recipient case management fee. There is no assignment or enrollment outside Chicago.

First Health, a Virginia firm contracted by IDPA to administer the Chicago HMHK managed care program, will operate the recipient enrollment system. Each eligible participant – children under age 21 and pregnant women – will be able to choose their primary care provider, the department told ISMS. Currently, IDPA and First Health are considering dividing these providers into two groups – Health Care Providers and Health Maintenance Organizations, according to information IDPA has given the Society. As defined by the department, health care providers would include primary care physicians, community health clinics, Federally Qualified Health Centers and IDPA partnerships. ISMS has expressed concern that these designations do not make it clear to recipients that they may choose a personal primary care physician and that they don't necessarily have to choose a health center or clinic.

Furthermore, if recipients have provider preferences and those physicians or clinics will accept them, the recipients will be given their first choice. But if recipients' choices can't be arranged or if they don't have a preference, First Health will use a currently unspecified "default" assignment process to place them, ISMS has learned. The Society is discussing with IDPA exactly how this system will operate.

"IT IS IMPORTANT to ensure that recipients are given the opportunity to choose or are assigned to providers in a fair and objective manner. They must know what options are available to them. We have discussed our concerns with IDPA and First Health and are confident that an equitable solution will be reached," Dr. Traugott said.

In meetings with Society officials, IDPA said it is interested in pursuing a project assessment that focuses on global issues including emergency room use, access to health care, changes in health status, quality of care and program costs, rather than scrutinizing the care delivered by individual physicians. IDPA has assured ISMS that all physician-specific quality assurance activities will continue to be handled through the department's existing Medical Quality Review Committee process.

First Health also is planning an HMHK physician hot line to give doctors general program information. The hot line services will provide recipient profiles at the physician's request and will serve as a specialty referral system. The patient profiles will include each date the recipient received care for which IDPA received and paid a claim. The profiles will also list diagnoses, procedures delivered and provider names.

For physicians treating Chicago recipients, the hot line will also provide claim authorization services. Under the Chicago managed care program, primary care providers must obtain prior authorization for any referral care they recommend for their assigned recipients. According to IDPA, all requests for authorization will be approved if the referrals are deemed necessary by patients' primary care providers and are made to Medicaid-enrolled specialty physicians.

Primary care providers trying to locate Medicaid referral physicians may contact the hot line, and First Health will provide the names of several physicians in a specific specialty and geographic area.

ISMS has questioned the details of the hot line's referral system. "First Health needs to ensure that referrals are distributed equitably among all participating physicians," Dr. Traugott explained. "Also, ISMS and IDPA are discussing the possibility of allowing primary care physicians to request referral physicians from particular hospitals. Hospital affiliation may be an important criterion to the primary care physician or the patient.

"Helping improve the health of mothers and children who receive Medicaid is of vital importance to ISMS, as it is to IDPA," he continued. "We support the goals of HMHK, but there are several operational details that need to be addressed. Through our continued communication with IDPA and First Health, we look forward to resolving the outstanding issues and making this program work for everyone involved." ■



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EDITORIAL

Economic credentialing

At the ISMS Annual Meeting, the House of Delegates adopted new policy on "economic credentialing" – the evaluation of physicians for medical staff membership, reappointment and clinical privileges based on economic factors rather than the quality of care they deliver. The new policy calls for due process in granting privileges to new medical staff and in recredentialing current medical staff. The House also directed that this policy be introduced as legislation as soon as possible.

ISMS acted immediately to develop language for an amendment to a bill. The Illinois Hospital Association reacted by telling lawmakers that this legislation would "effectively prevent hospitals from entering into exclusive contracts with physicians."

However, nothing in the bill prevents a hospital from entering into these kinds of agreements. "If anything, this amendment would guarantee appropriate protections to physicians currently holding exclusive contracts," Chairman of the ISMS Board of Trustees Jere E. Freidheim, MD, wrote to ISMS leaders.

Dr. Freidheim states in his letter that the IHA misrepresented the amendment, which was "introduced specifically because of hospital actions that violate the rights of physicians and patients alike." He concludes by outlining the basic problem: Economic credentialing can limit patients in choosing their own physicians and can prevent doctors from treating patients with whom they have established relationships.

An IHA memo about the bill uses the term "physician credentialing" – not economic credentialing – and defines it as the "process by which hospitals select physicians and monitor the quality of their patient care." But the bill deals with economic credentialing. And the "use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualification for initial or continuing hospital medical staff membership or privileges" *is* economic credentialing, according to the AMA.

The AMA also reports that economic credentialing is appearing in proposed amendments to medical staff bylaws nationwide. But, unfortunately, many physicians don't recognize and resist it, because authorization for economic credentialing isn't always obvious. For example, it could be in a provision requiring the staff to "comply with all hospital policies."

One of the most disturbing aspects of such credentialing is its potential impact on quality of care and patient choice. Patients admitted to a hospital may be treated by physicians who were granted privileges primarily on the basis of their profitability. Yet the criterion patients use in choosing a physician seems to be quality of care, not cost. A 1993 Gallup survey revealed that most respondents would rather pay more for care provided by physicians they choose than pay less for assigned physicians.

After all, isn't the physician-patient relationship at the heart of health care?

PRESIDENT'S LETTER

Exposés do more harm than good



By Arthur R. Traugott, MD

Last month, WMAQ-TV's health reporter, Joan Esposito, presented a series on Illinois' medical disciplinary process. The following is a response by ISMS President Arthur R. Traugott, MD, outlining the Society's concerns about the stories.

Dear Ms. Esposito:

The Illinois State Medical Society realizes the importance of, and has worked hard to build, a strong disciplinary system committed to protecting patients from incompetent or unethical physicians. However, sensationalizing individual cases, as in your recent exposé, may draw a large television audience but does little to serve our patients.

ISMS believes in a tough disciplinary process, as evidenced by our support of changes to the 1987 Illinois Medical Practice Act, including raising physician licensure fees from $100 to $300 to institute and maintain tougher licensing and disciplinary standards.

The low number of disciplined physicians in Illinois illustrates that Illinois' high standards for initial licensure are working.

ISMS also supported the mandatory reporting law in the early 1980s, which requires medical societies, hospitals and medical malpractice insurers to report any adverse actions against physicians to the state authorities for review. It also requires reporting of settlements or judgments in medical malpractice cases, although it is important to note that lawsuits in and of themselves are not valid indicators of physicians' competence. These reporting laws trigger review and, when warranted, further investigation by the Illinois Department of Professional Regulation and its medical disciplinary board.

The Illinois medical disciplinary process distinguishes between those physicians who require formal disciplinary action and those who need education, monitoring or counseling, which are not reported as formal disciplines against physicians' licenses. Physicians who violate our state's Medical Practice Act are appropriately disciplined; the system also encourages education of physicians, where appropriate, to correct specific practice problems they may have.

The low number of disciplined physicians in Illinois, as pointed out in your exposé, illustrates that Illinois' high standards for initial licensure, in combination with a thorough and effective disciplinary process, are working in this state. This low number of disciplines also proves that quality control measures are in place to recognize a physician's problems and take corrective measures before discipline is needed.

Finally, let me add in closing that Illinois' county medical societies throughout our state conduct peer review, mediation and ethical hearings on patient complaints. We would be pleased to further explore with you this system of professional self-discipline.

At a time when the physician-patient relationship is strained through increasing outside interference, sensationalized stories can cause more harm than good to the vast majority of competent and caring physicians in Illinois and the patients they serve. I hope you will work with the Illinois State Medical Society in any future follow-up to assure balanced and accurate coverage.



GUEST EDITORIAL

Meals-on-Wheels feeds hungry Illinoisans

By Brenda Edgar

The governor and I take great pride in seeing more and more public-private partnerships developing across the state. They're happening in the city and in the country, and they're involving people of all ages and from all walks of life.

One that is particularly exciting to me, personally, is Meals-on-Wheels Illinois. In fact, I have consented to be spokesperson for this program, because it has proved to be invaluable to older people at risk of losing their independence. Coordinated through the Illinois Department on Aging and Area Agencies on Aging, Meals-on-Wheels Illinois provides holiday and weekend meals to homebound seniors.

State and federally funded nutrition programs currently provide more than 17,000 meals per day to homebound seniors, and another 17,000 meals per day are served at group meal sites. Funding for holiday and weekend meals is often limited, however. The goal of Meals-on-Wheels Illinois is to stimulate private-sector financial support, as well as individual support, particularly in the form of volunteerism.

Entire communities have come together to call attention to this initiative. Fund-raising activities have ranged from bowling tournaments to corporate dine-outs, and sponsors have ranged from banks and insurance companies to restaurants, travel agencies and schools. The volunteers who actually deliver meals include CEOs and city officials, as well as reporters, ministers, teenagers and seniors themselves.

Thanksgiving and Christmas are the biggest holidays for the program, but more and more Illinois communities are trying to fill gaps on other holidays, such as Mother's Day and Father's Day, or even Memorial Day and Labor Day. What's most appealing to supporters of Meals-on-Wheels Illinois is that every penny raised goes exclusively for meals. And all it takes is a $5 contribution to pay for one home-delivered meal.

I encourage readers of *Illinois Medicine* to join with us in an effort that can make all the difference for a homebound older person. Become involved in local fund-raising or consider contributing to Meals-on-Wheels Illinois, c/o Project LIFE Area Agency on Aging, 2815 W. Washington, Suite 220, Springfield, IL 62702. If contributors want their donation to be used for meals in a specific city or county, they should indicate their choices when making the donation. Their donation will then be forwarded to the Area Agency on Aging that coordinates meal programs in that community.

For those who want to deliver meals to older people in their community, I suggest they contact the Illinois Department on Aging at (800) 252-8966. Agency staff can provide information about how to link up with local meal programs. Volunteers are often needed not only for special holidays but also for regular weekday deliveries.



Brenda Edgar *is Illinois' first lady.*

Again, Meals-on-Wheels Illinois is truly a partnership effort. It means that thousands of older people can look forward to the holidays, knowing that they can count on a warm meal, as well as a little companionship. I ask you to consider joining me in supporting a program that might make a real difference for your patients, your neighbors or even your parents.

GUEST EDITORIAL

Auxiliary plants the seeds of change

By Mindy Chadwick

I am honored to serve the Auxiliary and medical profession in Illinois. It is very humbling to walk in the shoes of my predecessors, all of whom have generously contributed their time and talent to improve the quality of life for Illinois residents. It is also an honor to be similarly challenged to continue these improvements and increase our potential as advocates for better health.

The need for the Auxiliary has never been greater. The problems of teenage suicide, AIDS, drug abuse, the homeless and the abused need our immediate attention. Through proper education, funding and volunteer support, many of these problems would not be insurmountable. We need to encourage preventive medicine. Good health is priceless; it cannot be purchased, but it can be safeguarded. Simple things can save lives. As Auxilians and physicians, we must urge the people in our communities to participate in the designated driver program, wear seat belts, use sunscreens, wear bicycle and motorcycle helmets, practice safe sex, stop smoking, drink less, eat low-fat diets and seek nonviolent resolutions to problems.

At the county level, we have committed our resources to free clinics, child advocacy programs, scholarships, health education, teen support cards, and the Partners for Health and mini-internship programs. Last year alone, county auxiliaries raised more than $80,000 to fund community health care projects, including four children's museums and two free clinics.

This year, I am asking you to commit to one area and make a positive change. As Mother Teresa said, "If you can't feed a hundred people, then feed just one."

As a state organization, the Auxiliary will focus on educating physicians and Auxilians about the wide-ranging effects of domestic violence. Violence in our society has reached epidemic proportions; homicide is now the second leading cause of death for young people between the ages of 15 and 24. Weapons are making their way into the hands of children. Many adolescents become perpetrators, having first been victims of violence themselves. Seventy-four percent of children living in Chicago have witnessed a murder or stabbing. Every 15 seconds, someone in the United States becomes a victim of domestic violence. Violence touches one-fourth of all American families, and 95 percent of those victims are women. It knows no economic bounds. And the American family is deteriorating as crime is increasing. The members of the Auxiliary intend to educate the public about the disease of violence and provide physicians with the necessary resources to help identify and treat abuse victims.

Although the need for the Auxiliary and the work of its members is more important than ever, there are fewer Auxilians. With each passing year, our membership decreases as Auxilians join other organizations and assume roles separate from those in medicine. However, one fact about the Auxiliary remains constant: We are all physician spouses, and as such, we are the best advocates for medicine and health care. We must assume the role of educators within our communities. We need to become involved in legislative issues affecting medicine by speaking for and about medicine to our elected officials and community leaders. You, too, need to become involved. All physician spouses interested in sharing their time and talent to serve their communities and the family of medicine should join the Auxiliary. It is incumbent on us to inspire action in others so that we can all speak with one voice for a brighter tomorrow.



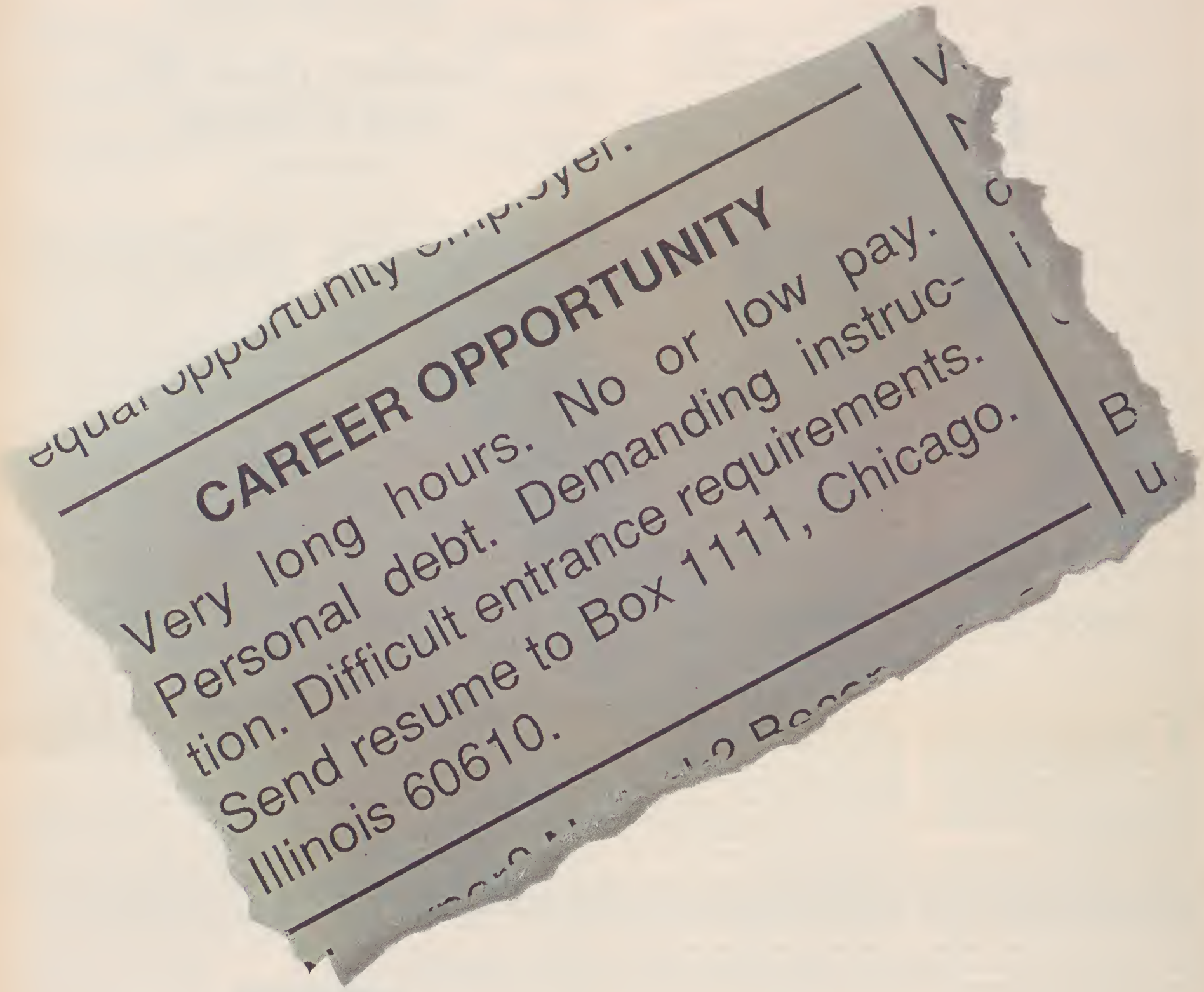
Mindy Chadwick *is president of the Illinois State Medical Society Auxiliary.*

I challenge you to plant the seeds of change, commitment and growth. Plant the seeds for health care reform and prevention. Our legacy is one of planting the seeds and sowing promises that we can keep to make this world a truly kinder and gentler place. If we do, we will reap a harvest of healthy individuals and communities.

It's time to renew your license

Illinois physicians beware: Your three-year medical and controlled substance licenses expire July 31. Physicians who do not renew their licenses by this deadline will technically be practicing without a license and could face disciplinary action by the Illinois State Medical Disciplinary Board. Exchange policyholders will also lose their medical malpractice coverage for the period of time they practice without a valid license.

Renewal packets were mailed to all Illinois physicians by the Illinois Department of Professional Regulation in late May. Any physician who has not received the renewal forms by mid-June should contact IDPR at (217) 782-0458. ■



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ISMIE Update

Malpractice Roundup

PAGE 10

Jury awards rise

Medical malpractice verdicts are not scaring away insurers. By Christine Woolsey

Jury awards in medical malpractice cases have inched their way up over the past decade, but brokers say liability insurance for physicians and hospitals generally remains plentiful.

"Even though there is not a straight line in the progression of jury verdict amounts from year to year, over the last 10 years one can see the amounts are increasing," said Brian Shenker, editorial director for Jury Verdict Research Series, which recently released a five-year analysis of medical malpractice jury verdicts nationwide.

JVR, a research unit of LRP Publications in Horsham, Pa., collects and analyzes data on personal injury verdicts.

Median medical malpractice verdicts against physicians, hospitals and the two as co-defendants have risen steadily over time, Shenker said. During the early 1980s, median verdict amounts hovered at $200,000. But, from 1985 to 1989, median verdict amounts totaled about $300,000, "and in the 1990s we are seeing verdict amounts around the $400,000 mark and above," he said.

JVR maintains a data base of about 80,000 plaintiff and defense verdicts and settlements rendered nationwide for personal injury claims against health care providers. Shenker acknowledged that only 10 percent of the 80,000 cases represent settlements, but said JVR's analysis accurately reflects a sampling of verdicts and settlements of all sizes.

In the 1990s we are seeing verdict amounts around the $400,000 mark and above.

JVR reported the median verdict value for all medical malpractice claims between 1987 and 1991 was $350,000, with plaintiffs recovering some or all of the award in 39 percent of the cases. In 1991, the median verdict for all claims was $465,000.

In "Trends in Health Care Provider Liability," JVR authors point out that median verdict amounts provide "the most accurate gauge of the norm." Mean verdicts, which are mathematical averages of all verdicts analyzed, "can often be skewed by a small number of very high verdicts and give a distorted view of the data," the authors say.

Some brokers point out that the $350,000 median verdict figure may not accurately reflect the overall amount of all medical malpractice verdicts and settlements.

"It may be a little low," observed Keith Burkhardt, regional health care director in the Chicago office of Sedgwick James National Division. To get a more accurate feel for malpractice verdicts, one must look at the median verdicts for specific injuries, he said.

JVR found the two most frequently reported injury claims are for brain damage and wrongful death. Brain damage cases primarily consisted of severe and catastrophic injuries. "Severe" brain injuries can include deficits in intelligence, thinking, judgment and behavior, while "catastrophic" brain injuries may involve profound mental retardation and the need for custodial care, according to JVR.

In its five-year analysis, JVR reported that the median verdict amount for medical malpractice claims for brain damage was $2.1 million. Verdicts during that period ranged from $41,052 to more than $54.8 million.

Meanwhile, the median verdict amount among medical malpractice claims for wrongful death was $550,000. The majority of wrongful death cases JVR analyzed involved infants who died during childbirth.

Those verdicts ranged from $244,523 to $1 million, JVR found.

The researchers also discovered the three most frequently reported liabilities for providers relate to childbirth, diagnosis and surgery.

Childbirth liabilities include inadequate prenatal care and injuries suffered by the infant or mother in Caesarean section procedures.

Plaintiffs recovered in 51 percent of the cases alleging injuries during childbirth in the five-year period, and the median verdict totaled $850,000, according to JVR.

Malpractice claims related to diagnoses typically include improper and/or delayed evaluation of a plaintiff's injuries. Plaintiffs recover in about 40 percent of these cases, with a median verdict of $500,000.

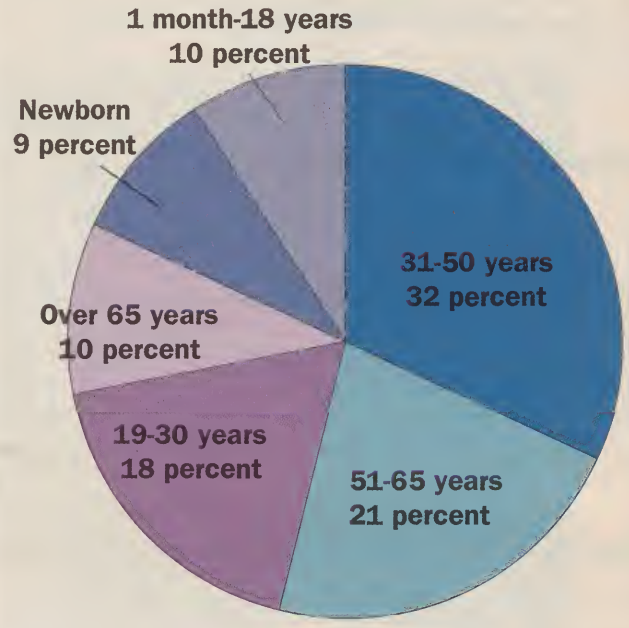
Plaintiffs alleging surgical malpractice typically claim that surgery was improperly performed, unnecessary or delayed. These plaintiffs recover in 39 percent of the cases, with a median verdict of $254,850.

"The liabilities cited by JVR are definitely problem areas for our policyholders," said a spokesperson for St. Paul Fire & Marine Insurance Co. in St. Paul, Minn.

St. Paul Fire & Marine, the nation's largest medical malpractice insurer, most frequently sees medical malpractice claims involving brain damage

(Continued on page 10)

Percentage of ISMIE claimants by age



All open and closed claims from Jan. 1, 1985, to April 30, 1993

Source: Illinois State Medical Inter-Insurance Exchange

Access to mental health, general records explained



Access to records that are kept as part of services provided to individuals with mental health problems or developmental disabilities is subject to the provisions of the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110/1 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 91 1/2, par. 801, et seq.]. Specifically, Section 4 provides a list of people or entities who have a right to inspect and copy a recipient's record:

- The parent or guardian of a recipient under 12 years of age;
- The patient if he or she is 12 years of age or older;
- Any other person acting on the recipient's behalf if the recipient so authorizes in writing;
- The parent or guardian of a recipient who is at least 12 years of age, but under 18, if the recipient is informed and does not object or if the therapist does not find compelling reasons to deny access;
- The guardian of a recipient who is 18 or older;
- The Mental Health and Developmental Disabilities Medical Review Board.

There are specific consent guidelines for disclosing records and communications under the Mental Health and Developmental Disabilities Confidentiality Act. Only information relevant to the purpose for which disclosure is sought may be released. Blanket consent to the disclosure of unspecified information is not considered valid.

If a parent or guardian is denied access, that person may petition the court for access. Under a valid court order, disclosure of confidential information may be required. If physicians receive requests for the release of confidential information pursuant to a subpoena or

(Continued on page 11)

MALPRACTICE ROUNDUP

Removing malpractice jurors on the basis of race

As featured in *The Malpractice Reporter*, the appeal of a Kentucky medical malpractice case hinges on whether the defendant-physician's attorney used his peremptory challenges to remove African-Americans from the jury solely because of their race. About one month after the physician, a Caucasian orthopedic surgeon, surgically placed a pin in the broken hip of an elderly African-American man, an infection was discovered, which led to the amputation of the patient's right leg. The patient subsequently sued, and a jury verdict was returned in the physician's favor.

The physician's attorney had used his three peremptory challenges to remove two African-American jurors and one Caucasian juror, leaving only one African-American juror on the panel. This 13th juror was removed from the panel by lot before submission, leaving the decision to 12 Caucasian jurors. The plaintiff's attorney appealed the verdict using a 1991 U.S. Supreme Court ruling that once one party demonstrates that the attorney for the other party excused jurors on the basis of race, the burden shifts to the other side to show that this action was "neutral," not discriminatory. Therefore, if the patient's attorney can show that the physician's attorney used his peremptory challenges to discriminate against African-American jurors based on their race, the defense attorney will have to prove a neutral reason for removing the two African-American jurors. ■

Deposition as expert proof

As reported in *Medical Malpractice Law & Strategy*, the Pennsylvania Superior Court ruled that information from a defendant physician's deposition can be used by plaintiffs as expert testimony at a trial. Following a surgical procedure performed by the defendant, the plaintiff experienced facial paralysis. At his deposition, the defendant testified that facial paralysis was a possible risk of the surgery and admitted he had failed to warn the plaintiff of this risk. At trial, however, he testified that he did not regard facial paralysis as a risk. The plaintiff, who had not retained an expert, introduced the defendant's deposition to satisfy the requirement of expert medical testimony.

The court noted that deposition testimony may be used by an opposing party for "any purpose" and that a witness's prior inconsistent statements can be used as substantive evidence. The superior court allowed the plaintiff to present the case to a jury. ■

Discrimination law tested

As reported in *Medical Malpractice Law & Strategy*, a San Diego jury found in favor of a urologist who stopped treating a homosexual AIDS patient for impotence because he feared he could be contributing to the spread of the virus.

The suit was based on a San Diego law that bars discrimination against individuals with HIV and AIDS except when the alleged discriminator can prove the action was taken because of a justified concern for the public's health and that there was no less discriminatory means to protect the public. The doctor did not contest the discrimination but claimed he was protecting the public's health. According to the plaintiff's attorney, the plaintiff has been sick since 1985 and is involved in a monogamous relationship. He said they are considering an appeal. ■

Administration considers 'enterprise liability'

Reports from Washington indicate the Clinton administration's health care reform task force is considering eliminating medical malpractice lawsuits against physicians and hospitals. Instead, through "enterprise liability," insurers and providers of health care plans would bear the liability burden.

Opponents of the idea, including the AMA and other physician groups, say such a plan would not reduce malpractice costs or prevent physicians from wasting time defending nonmeritorious suits. They also contend that it could encourage frivolous lawsuits, since suits would be filed against an entity and would not jeopardize the physician-patient relationship.

Opponents also believe enterprise liability could lead to increased economic credentialing of physicians, particularly for doctors practicing in high-risk specialties who tend to be sued more often. In addition, physicians would lose control over making settle-or-defend decisions; the insurer or provider could opt to settle cases that a physician or hospital considers defensible. ■

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Jury awards rise

(Continued from page 9)

to children – resulting, for example, in cerebral palsy – and improper or missed diagnoses.

"The most frequently reported problems with diagnoses involve cancers, particularly breast cancer, and heart attacks," the spokesperson said.

To combat malpractice claims, the insurer offers policyholders comprehensive risk management services and also works with a nationwide network of defense attorneys who specialize in these areas, he said.

Shenker of JVR noted that plaintiffs do not recover in medical malpractice cases as often as in other liability cases, like automobile accidents.

"The recovery rate in medical malpractice is about 30 percent to 40 percent vs. about 50 percent to 60 percent in other liability areas. But, for similar injuries, most of the time the verdicts against physicians are much higher" than verdicts against businesses or other defendants, he pointed out.

Despite the upward trend in jury awards, physician medical malpractice and hospital professional liability insurance remains generally plentiful, Sedgwick James' Burkhardt noted.

Coverage is more expensive in some areas of the country, like California, he said. "But if you look at Chicago, which is a fairly typical market, there have actually been some new entrants in the market during the last 24 months." ■

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Guidelines

(Continued from page 9)

court order, they should have the documents reviewed by legal counsel prior to disclosing any information.

FOR PHYSICIAN OFFICE RECORDS, information relative to the "diagnosis, treatment, prognosis, history, charts, pictures and plates, kept in connection with the treatment of such patient," is subject to release, whether or not it is in the patient's actual medical record. This includes notes and laboratory results. If secondary records are a part of the patient's entire record, they are also subject to release, and a disclaimer regarding the secondary records is not needed. However, financial records, which may or may not be part of the actual medical record, need not be released.

> *Financial records, which may or may not be part of the actual medical record, need not be released.*

When records are requested under circumstances related to Worker's Compensation, it is customary for an attorney to send a cover letter along with the patient-executed medical release. In the typical release, the patient authorizes the physician to release all medical records to a certain attorney or firm.

Individuals who can gain access to the medical records of a deceased, incapacitated or incompetent patient include personal representatives such as guardians, administrators and agents designated under durable powers of attorney for health care.

FOR HOSPITAL RECORDS RETENTION, the statute of limitations on damages is used as a guide [735 ILCS 5/13-212 (1992)], formerly [Ill. Rev. Stat., ch. 110, par. 13-212]. No action for damages for injury or death against any physician or hospital can be brought more than two years after the date on which the claimant knew – or through the use of reasonable diligence should have known – or received written notice of the injury or death for which damages are sought, whichever date occurs first. However, the action cannot be brought more than four years after the alleged act or omission occurred.

There are some exceptions to the previous statement. If the action accrued to an individual under the age of 18, no action for damages for injury or death against a physician or hospital can be brought more than eight years after the date on which the alleged act or omission occurred, provided that the cause of the action is not brought after the person's 22nd birthday. Further, if the person entitled to bring action is under legal disability or imprisoned at the time the cause of action accrues, the period of limitations does not begin to run until the disability is removed or the person is released from prison.

According to [735 ILCS 5/13-215 (1992)], formerly [Ill. Rev. Stat., ch. 110, par. 13-215], if a person fraudulently conceals the cause of such action, the action may be brought within five years after the person entitled to bring it discovers the cause of action.

According to the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110/1 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 91 1/2, pars. 801 - 817], damages may be brought against a physician at any time.

According to the Hospital X-ray and Roentgen Photographs Act [210 ILCS 90/0.01 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 111 1/2, par. 157-11], hospitals must retain such photographs or films for five years. However, if the hospital is notified before the expiration date that litigation involving a record is pending in court, the hospital must keep that record for 12 years from the production of the film or until notified in writing by the plaintiff's attorney, with the approval of the defendant's attorney, that the case has been concluded.

There is no legal answer as to whether original x-rays can be given to another physician's office. If a copy request can be fulfilled, there is no reason the original x-ray can't be loaned to the requesting physician.

When a hospital closes, hospital records are usually shipped to the nearest hospital. However, that is not always the case. The Illinois Department of Public Health maintains a current listing of the location of all such records. For that information, physicians may call (217) 782-7412.

For specific guidelines, see the ISMS brochure "A Physician's Guide to Medical Record Access and Retention." ■

Editor's note: This is part of a series on medical-legal issues written by the ISMS Medical Legal Council. These guidelines do not necessarily represent ISMS policy. They address legal concerns that physicians commonly express to ISMS and are intended to serve as only a guide for physicians, not specific legal advice.

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Responding to seni

Physicians who take the time to liste

BY JANICE
PHOTOS BY J

As any physician who treats senior citizens can tell you, the difference between older people and other patients is not simply chronological. Collectively, seniors have special needs and concerns.

"They often have multiple, chronic conditions that decrease their ability to be independent, require multiple medications and impair their senses so that they can't relate as well to others," said Daniel K. O'Brien, MD, assistant professor in the department of family practice at Southern Illinois University School of Medicine in Springfield. "From a social standpoint, they are retired and therefore are much less financially able. And they've lost spouses, siblings and friends, so they're often alone."

CARING FOR SENIORS involves more than diagnosing and treating diseases. Physicians who treat seniors should make a special effort to find out what's going on in all aspects of their patients' lives. They should appraise each senior patient's psychological condition, ask about living situations, consider the complications of multiple medications and recommend community resources that can supplement their own care giving.

All these matters can be handled through good communication. "Seniors would like physicians to listen more and give them more time to ask questions," said Margaret Scovitch, RN, MSN, director of the wellness clinic at the Belleville Area Senior Center, Belleville. "Many older people have hearing impairments and may need to lipread, so they'd like physicians to establish eye contact and face them when they are speaking."



Even patients who hear everything you say may not understand the information. So ask seniors whether they've understood and have them restate what you've told them. "Don't shout," said Scovitch. "For people with hearing aids that doesn't improve understanding; it only makes more noise."

Communication goes both ways. Many seniors view their office appointments as opportunities for someone to listen to them. "Most are quite aware that certain things can't be treated, but they want to know that there's nothing else going on that may be a worsening of their condition," said John M. Sultan, MD, a Highland Park internist. "Often they just want to talk about family and friends. I think listening is part of what a general internist does."

Taking the time to listen and communicate clearly can make a big difference in one of the most confusing issues for many seniors, multiple-medication compliance. The vast majority want to comply with physicians' orders but may have difficulty following instructions, said Joan E. Cummings, MD, a specialist in gerontology and director of the Edward Hines Jr. VA Hospital. "Younger individuals forget to take antibiotics four times a day, and that's only one pill," she said. "Seniors may be on four or five different medications, each with its own schedule. How many of us could remember all that?"

Dr. Cummings suggests that physicians minimize the number of drugs they prescribe and simplify regimens by giving medications in doses that can be taken once or twice a day instead of three or four times. "The primary thing is to prescribe only drugs you absolutely have to. Patients can be given special dispensing boxes or instruction sheets to help them keep track of what to take when."

Again, communication is of the utmost importance. Patients need to be told about the possible side effects



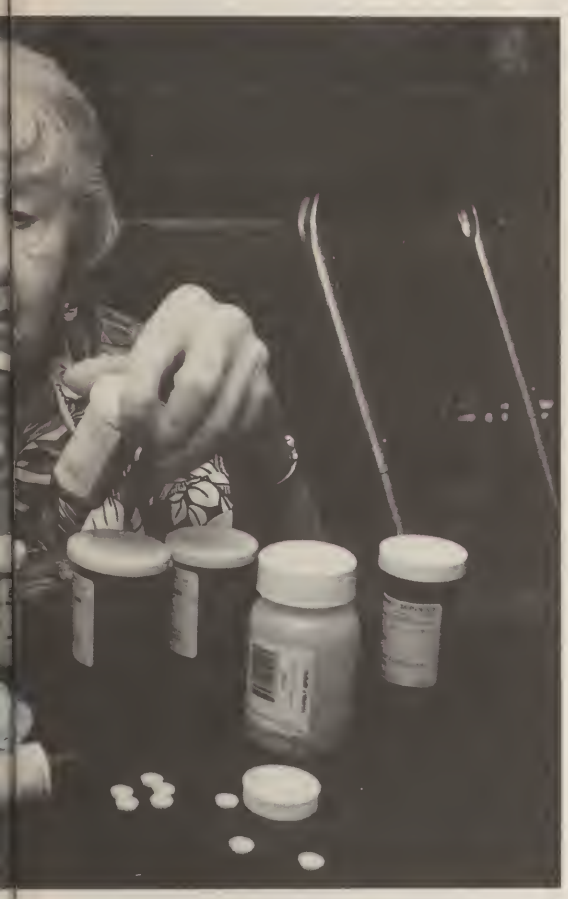
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of the drugs they are taking. In addition, they should be warned not to take friends' medications, no matter how well these medications have worked for others.

Compliance problems increase when seniors are treated by more than one physician. "Seniors need to have someone at the helm of their care," said Gary M. McCray, MD, assistant professor of medicine at Loyola University Medical School. "Their primary care physician needs to find out what drugs subspecialists have prescribed."

One way to find out is to have patients bring in all of their medications – both prescription and over-the-counter – when they come for an office visit. Another option is a home assessment by a state or local agency. "Physicians can't be the whole answer for seniors," said Dr. O'Brien. "In regard to their social needs, we need to enlist the assistance of others. Community services and health care agencies are available to help meet their needs and allow them to live independently at home."

VISITING NURSES and other health care workers who perform assessments can also evaluate seniors' food supply, check the physical safety of their home and check for possible signs of elder abuse. "Elder abuse is estimated to be more common than child abuse," said Dr. Cummings. "It can be physical, but psychological and financial abuse are more common."

Many larger communities have elder abuse services available through senior centers. "Often patients tell you things that raise your curiosity," said Dr. O'Brien. "If your patient doesn't object, it's really important to report possible abuse."

Physicians who treat seniors should also be alert to signs of depression. "Depression is hard to diagnose in seniors, said Dr. Sultan. "Some common signs are fatigue and loss of interest in usual activities. Their

(Continued on page 14)

Join the healthy partnership

Programs designed to enhance the relationship between physicians and their older patients have been an ISMS priority for several years. The Society created the Partners for Health program to help senior citizens work in a partnership with their physicians to maintain their health. As part of the program, ISMS developed a physician speakers bureau that addresses seniors groups on issues important to them, especially physician-patient communication. Physician speakers also discuss pertinent topics for older audiences such as diabetes, heart disease, arthritis, Alzheimer's disease, medication and advance directives.

When speaking to senior groups, physicians take copies of the Society's Healthy Partnership Kits to distribute. Each kit contains a variety of brochures developed to ease the processes of finding and communicating with a doctor. In addition, the kit answers frequently asked questions about billing, insurance and sources of more information. Pamphlets are included for advice on transferring medical records and preparing for office visits.

The kit also stresses that seniors should be familiar with their medical histories and medication schedules. To help them do that, the kit provides a personal health record for "vital statistics" such as blood type, allergies and vaccinations. The health record can serve as the basis for communication between patients and their physicians. And after an office visit, patients can record the discussion, their doctor's instructions and any new prescriptions. By detailing such information, elderly patients are better prepared to participate in decision making.

The Healthy Partnership Kit also contains a brochure explaining Medicare in simple terms and touching on cost containment and mandatory assignment. A bill-paying log sheet helps patients account for their health care dollars; separate lines are provided for patients to enter the costs of services and the amount paid by Medicare, supplemental insurance and themselves.

Seniors groups throughout Illinois have praised the Partners for Health program, the physician speakers bureau and the Healthy Partnership Kit. Physicians participating in the program receive a speaker training packet, which includes a sample speech, a public speaking guide, fact sheets from the Illinois Chapter of the American Geriatrics Society and a brochure explaining how to make arrangements for the speech. The ISMS public relations department schedules the speaking engagements and contacts physicians enrolled in the program when groups in their area request a speaker. Because of the great demand for physician speakers, particularly in downstate counties, the Society is seeking additional physician volunteers to participate in the Partners for Health Program.

Physicians interested in joining the speakers bureau or who would like to request Healthy Partnership Kits for their patients may contact the public relations department at (312) 782-1654 or (800) 782-ISMS. ■

– Anna Brown

AIDS numbers escalate, trends change in Illinois

[SPRINGFIELD] The numbers are in. And for 1992, they show a 17-percent increase in reported AIDS cases in Illinois over 1991, according to the Illinois Department of Public Health. Last year's 1,899 AIDS cases bring Illinois' cumulative total to 8,202 – the sixth highest in the United States.

State health department statistics also indicate a trend away from the early predominance of the disease in Caucasian homosexual/bisexual men. Although 1992 figures show that most reported cases remain confined to members of the homosexual/bisexual male community (accounting for two-thirds of Illinois' AIDS cases reported since 1981), the incidence of AIDS increased most significantly among injecting drug users, women, heterosexuals and minorities. Cases in those categories were up 71 percent, 47 percent, 36 percent and 31 percent, respectively. African-Americans and Hispanics accounted for 56 percent of the new AIDS cases reported in 1992.

In related news, a recent University of Illinois at Chicago study reveals that women are at risk for exposure to AIDS through unprotected sex with men they don't know are bisexual. Fifty-four percent of the 467 male participants in the study admitted their female partners were unaware of their homosexual activity. Of the women who were aware, 44 percent did not discover their partners' bisexual orientation until after they'd had sex with them. The study was conducted by Joseph Stokes, a psychology professor, and David McKirnan, an associate psychology professor.

In light of the new statistics, IDPH Director John R. Lumpkin, MD, said Illinois should implement innovative AIDS programs such as the $2.5 million prevention and education effort targeting IV drug users that was recently announced by the governor. ■

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Auxiliary to become the Alliance

[OAK BROOK] The Illinois State Medical Society Auxiliary House of Delegates held its Annual Meeting April 21-22 in Oak Brook. Following in the path of the AMA auxiliary, the ISMSA voted to change its name. It will become the Illinois State Medical Society Alliance in 1994, provided the group passes necessary bylaws modifications at next year's Annual Meeting.

During the meeting, the Auxiliary also presented its annual Humanitarian Awards. The awards are given to individuals who make outstanding contributions in their field of service. All nominees are recommended by their home counties. Carolyn Chapman, of Belleville, received the ISMSA Humanitarian Award in the member category. An active Auxilian since 1952, she has also donated her time and talents to many philanthropic organizations.

In the nonmember category, physicians Christian F. Weigel, MD, an internist, and Nancy S. Weigel, MD, a family physician, both of St. Louis, were recognized for their efforts to increase access in St. Clair County. The ISMS members operate an indigent care clinic in East St. Louis.

For more information about the Auxiliary's current and upcoming programs, see new Auxiliary President Mindy Chadwick's guest editorial on page 7. ■

Seniors

(Continued from page 13)

appetites may fall off or they may keep to themselves. Some get constipated. Depression can be mistaken for dementia, so physicians should consider depression when they're dealing with someone who's had a change in his or her alertness."

THE ISOLATION THAT many seniors feel with the loss of friends and relatives contributes to depression. "Doctors have to do more with social issues," said Dr. Cummings. "They should ask about feelings of frustration or loss, and be sensitive to the grieving process and how long it lasts in older individuals. As we follow them for medical problems, we need to look at these issues and ask how they're doing."

That's why asking questions and taking time to listen to answers is such a major component in treating seniors. "If you take a little time at the front end, you get a lot more information, and it saves you time in the long run," said Scovitch. "You also get a more compliant patient." ■

P. John Seward, MD: Focusing on physician constituents

He says now is the time for increased communication among physicians, and as an AMA trustee seeking re-election this month, he intends to promote that goal. By Tamara Strom

With the uncertainty facing physicians about the impending changes promised by health care reform, the leadership provided by organized medicine is in greater demand than ever. P. John Seward, MD, a Rockford family physician, is ably filling that role.

As an AMA trustee, Dr. Seward represents the interests of physicians and their patients within organized medicine and to the general public. With the Clinton administration's commitment to enacting health care reform, physicians must have a place at the negotiating table to ensure the high standards of U.S. health care do not suffer in the process, Dr. Seward said. In addition, organized medicine must communicate with grassroots members so that physicians on the front lines of health care delivery aren't left in the dark.

"I see great confusion, tension and fear among some physicians and a perception of dislocation about how they will interact with patients under a new health care system," Dr. Seward said. "By traveling around the country and speaking to physicians, I try to alleviate some of that angst."

I really enjoy practicing medicine. It's still my vocation and my desire.

Dr. Seward said he believes the reform debate has been preoccupied with cost. "We have to look at the importance of value. By that I mean safeguarding the high-quality care already delivered to the majority of patients, while at the same time trying to get a handle on rising costs. We must be more value-driven in our considerations about health care reform. The patients must come first. That's where I think we've staked out the higher path. There are some definite principles the AMA is committed to seeing become part of health care reform, and these are all based on delivering quality care."

SAFEGUARDING PATIENTS' RIGHTS to choose their personal physicians is paramount among those concerns, Dr. Seward said. "Recent polls have shown that patients really want that choice of physician. Not being able to have that freedom of choice would cause the American public a great deal of concern."

Dr. Seward said he believes medicine's image has suffered because of myths perpetuated by the media and the public. "In some ways, medicine is taking the rap for the ills of the whole system." But at the same time, he said, patients routinely rank their personal physician as the person they most respect. "We must continue to deserve that accolade. The mischaracterization of some of our positions has contributed to the view of the AMA as an old, conservative, entrenched, economically focused organization. [This perception] is not true."

To illustrate his point, Dr. Seward listed the visible leadership position organized medicine has taken on public health issues, such as the AMA's "pioneering work on smoking cessation." The AMA has attacked Marlboro's cartoon spokesperson Joe Camel as a symbol of the tobacco industry's insidious campaigns aimed at attracting young smokers. The association's educational anti-violence campaign is also improving the country's public health. "That project is more important today than when we started it a few years ago," he said. "[Physicians] are the ones who very quickly see the impact of these problems on our patients."

Dr. Seward stressed that the nation also must come to grips with the crises of drug abuse and AIDS. "These are huge, huge issues. We can legislate all kinds of changes that can deal with cost of care, but those things are just Band-Aids. Until you get to those major societal issues, we won't really be addressing cost. Drugs and AIDS have tremendous costs to the American public in both lost lives and money."

These are the types of messages Dr. Seward said are critical for AMA and ISMS member physicians to hear. That's why he spends more than one-third of his time traveling throughout Illinois and other states talking to his colleagues. Meeting with other physicians and exchanging ideas is the most gratifying aspect of his position as AMA trustee, he said. "To go out to county medical societies and bring the message about what AMA is, is fun and important. Sometimes even physicians have the perception that AMA is an impersonal institution. What I find fascinating is how many physicians are unsure about what organized medicine is all about. My taking the time to listen to their concerns and take them back to the AMA is just as important as my speaking to them. It's a two-way street. I need to know what their real feelings are out in the field. We may be discussing issues at a different level [during an AMA board meeting], and I could be out of touch with [grass-roots physicians'] feelings and beliefs. I need their input."

THE ONLY DRAWBACK of his service in organized medicine is the time he loses from his practice and his patients. Dr. Seward has practiced in Rockford for 26 years,



Mary Jo Phalen

starting his professional career there in 1967. "I really enjoy practicing medicine. It's still my vocation and my desire. One concern I have is to make sure I'm giving [my patients] the appropriate care, since I'm gone so much. This is one of those tough little questions I have to ask myself. So it's bittersweet in a way. But I've been blessed with superb partners."

Dr. Seward said he also draws on the support of his wife, Dusty, and their three children, Bill, Chet and Alaire. And his family contributes to organized medicine by unselfishly giving up some of their time with him. In addition to the days he's away from home, Dr. Seward spends some weekends covering for his partners, to compensate for his time away. "But my kids are grown. They're in college and grad school, so that helps a lot. And without a helpful wife, I'd be lost. I have one who keeps me sane."

Dr. Seward's seat on the AMA board is up for re-election, and he is seeking an additional term in office. He said he wants to help physicians prepare for the future. "I always try to listen to physicians. And I bring the most honest approach I can to issues."

BEING FROM ILLINOIS – a unified state within the federation of medicine – is a source of pride, he said. "One advantage I have is that I was brought up in organized medicine in a unified state. So my outlook is maybe a little broader. You need to try to see what would be best for all physicians, not just a certain group or specialty. It doesn't matter if you're a rural physician or a big-city doctor, a pediatrician or a surgeon. All the core issues affect all physicians and their patients."

It's a "good feeling" to say I'm from Illinois, Dr. Seward added. He was heartened when the ISMS House of Delegates voted in April to stay unified. "It sets a certain pattern of being very much involved. Illinois physicians are very proactive and dynamic in being able to espouse our views. [Unification] says physicians from Illinois are well versed on the issues – that they are willing to be heard and want to be heard." ■

Illinois delegation prepares for AMA Annual Meeting

The Illinois AMA delegation met at the ISMS Annual Meeting to prepare for its participation in the AMA Annual Meeting June 12-17 at the Chicago Hilton Hotel. The ISMS delegation to the AMA comprises 21 delegates and 17 alternate delegates.

Reports, resolutions and discussions focusing on health care reform will probably dominate the meeting. P. John Seward, MD, AMA trustee from Rockford, has led the AMA's health care reform efforts through his chairmanship of the Technical Advisory Committee on Health Systems Reform. Dr. Seward is seeking re-election to the board for a second three-year term.

"The Illinois AMA delegation has a reputation of being very organized on behalf of its candidates," said Joseph B. Perez, MD, AMA delegation chairman from Rockford. "We've been working for John Seward since last December. We're lucky that he has done an outstanding job in his first term as trustee and that he is well known and well liked. There are several nonincumbents running this year, so our strategy is to make sure he's elected on the first ballot."

Several ISMS member physicians, residents and students are seeking AMA elected offices. Howard Chodash, MD, a resident physician in gastroenterology at Northwestern University Medical School, is seeking a second term as the resident member of the Council on Medical Education.

Joseph L. Murphy, MD, a Chicago internist, is seeking re-election for a second term as alternate delegate to the AMA Hospital Medical Staff Section.

Charles Rainey, of Loyola University's Stritch School of Medicine, is seeking to be the speaker of the AMA's Medical Student Section. Heidi Dunniway, of the University of Illinois at Urbana-Champaign School of Medicine, will run for the AMA-MSS Governing Council. ■

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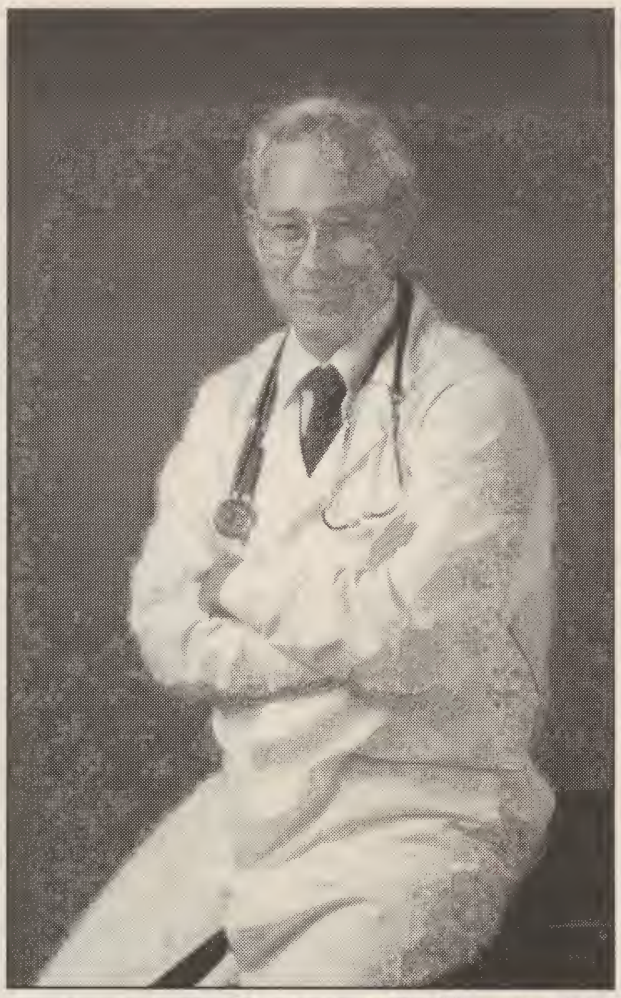
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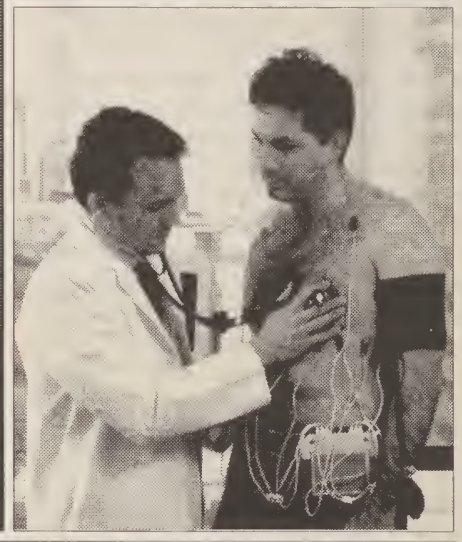
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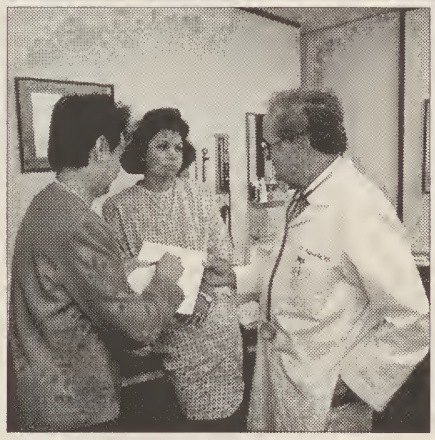
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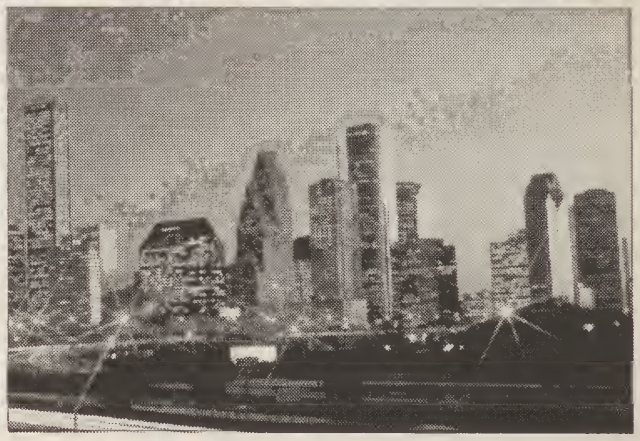
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Stress of medical marriages discussed

HIPPOCRATES' HANDMAIDENS: An author, who is also a physician's wife, contends that doctors' families maintain home lives vastly different from those of other professionals. By Tamara Strom

[OAK BROOK] Many of the people who buy Esther Nitzberg's book order it under an assumed name and take it home from the bookstore in a plain brown wrapper. She believes they do that because there's a stigma attached to the subject – the unique strains and stresses of medical marriages.

"Not every wife has to wait until 10 or 11 o'clock for her husband to come through the door at night and then feel guilty about asking him to change the baby's diaper. Not every wife lives this way. Not in 1993," Nitzberg told a physician spouse audience April 22 during the ISMS Auxiliary Annual Meeting.

Nitzberg said she wrote the book *Hippocrates' Handmaidens: Women Married to Physicians* as a long message to her husband. "Medicine affects us all. How we live, how we take our leisure time – if we're fortunate enough to have some – our sex lives and our social lives," she said. "The institution of medicine has to change. We fall in love with men; we don't fall in love with doctors."

> *We fall in love with men; we don't fall in love with doctors.*

To research the book, Nitzberg interviewed 125 doctors' wives around the country. "Women really seemed to want to talk about what their lives are like. What touched me was that no one had asked them before."

She also interviewed the wives of other professionals, such as attorneys, to get a sense of the similarities and differences. She found more differences. "One of the sad things about medicine is that it trains out humanity in its providers" during medical school, internships and residencies. "That affects you and me. They absolutely block it out. Even though these doctors are great with their patients, those same people are so drained of emotion [when they come home], they have nothing left for us and our children."

One of the most frequent complaints Nitzberg hears about her book from physician spouse readers is that it doesn't include a chapter detailing corrective actions wives can take. But that's not why she wrote the book, she explained. "The first thing is to say out loud in print that this is how we live. Then each of us can decide what to do. We have to accept that it exists first."

Nitzberg stressed that her message is not intended to dissuade women from marrying doctors. Instead, she said she is issuing a challenge to physician spouses to place more value on their own roles within the family. Many physician families revolve around only the doctor's busy schedule, a point mentioned by several audience members. Physicians' wives must build their self-esteem, she said, adding that women typically have lower self-images than men.

"Sometimes we are presumed to be a physician spouse – only a doctor's wife," she said. "We must present a different picture to the public, to each other and to ourselves." Physicians' wives are "not to be shelved, left in the shadows."

Doctors' wives also tend to be isolated. "Even as Auxiliary members, we are too isolated. Auxiliaries are brought together based solely on our husbands' chosen careers. I'd like to see others become involved in auxiliaries or see you use your energies in other areas as well."

Nitzberg said she is sometimes discouraged by the public's perception of physician spouses. When she has asked people what they think about doctors' wives, their responses ranged from "spoiled and selfish" to "dilettante." Nitzberg calls these answers very strange, considering all the work Auxilians do for good causes, independently and as Auxiliary members. "People don't identify with people of privilege, and in many ways we are privileged, at least economically. But we bleed when we're cut. We have problems just like anyone else." ■



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Speaker Esther Nitzberg tells Auxilians that medical marriages experience unique stresses.

Auxiliary Annual Meeting highlights



Auxilians (left) gather at the ISMS Auxiliary Annual Meeting in April. Auxiliary Second Vice President Kathy Kelley (below) presents plaques to the winners of the group's 1993 Humanitarian Awards: member Carolyn Chapman (below left) and nonmembers Dr. Christian Weigel, MD, and Nancy Weigel, MD (below right).





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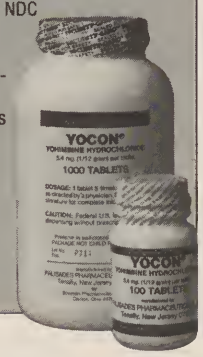
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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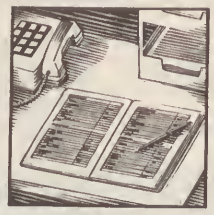
Avoiding sexual harassment

By James Dwyer

There is a legal axiom that anything you say or do can or will be used against you in a court of law.

That admonition is being taken seriously in today's workplace, where sexual harassment has made people more cautious about their conduct around members of the opposite sex.

The health care environment is not immune from these concerns. Most hospitals have strict policies regarding sexual harassment, and their physician administrators are routinely briefed on these policies by the hospital counsel or human resources personnel.



"We will meet occasionally with the administrative physicians about a variety of employee issues, including sexual harassment policy," noted Joan Lebow, vice president and legal counsel for Illinois Masonic Medical Center in Chicago. "The administrative physicians then are expected to relay this information to the resident physicians, so that they are aware of what is and what is not acceptable behavior." Although hospital-employed physicians and resident physicians receive guidelines for behavior, the same cannot be said for the hospital's medical staff.

"We do not, as a rule, brief the medical staff members on these guidelines, since they're not technically employees of the institution," Lebow said, adding that she has not had to confront a medical staff member on a sexual harassment charge. She pointed out that the vast majority of the health care professionals in the field maintain a true sense of professionalism that reduces the chances such incidents will occur. However, she claims the potential for sexual harassment does exist, because of the predominance of men in authority positions in medicine.

"Medical staff members are expected to conduct themselves in a professional manner that does not create uncomfortable sexual situations for their fellow hospital workers," she noted. "We hope that when medical staff members were resident physicians, they received proper guidance about what is and what is not appropriate behavior."

ROCKFORD FAMILY PHYSICIAN William E. Kobler, MD, chairman of the ISMS Hospital Medical Staff Section Governing Council, said his colleagues discussed the issue at length during the Clarence Thomas-Anita Hill hearings. "We all began re-evaluating how we relate to those we literally and figuratively touch during the natural course of our day."

Dr. Kobler said he believes most physicians have learned to be more careful about what they say and how they act around members of the opposite sex. He added that most professionals have become more aware of the sensitivities of co-workers and patients alike.

"We now realize that we can say the same thing to two different people and evoke two totally different reactions," Dr. Kobler continued. "I think many professionals are concerned that situations alleging sexual harassment may really be nothing more than a misunderstanding of someone's intentions."

The type of misunderstanding Chicago plastic surgeon Robert M. Gerson, MD, has noticed among some of his colleagues has caused him to re-examine how he interacts with women in the hospitals at which he has privileges.

> *We all began re-evaluating how we relate to those we literally and figuratively touch during the natural course of our day.*

"A fellow surgeon I know used to have a certain playful manner around surgical nurses, but he never meant any harm," Dr. Gerson said. "One day, a nurse reported him to the hospital administrator, and he was reprimanded. Now, when he goes to that hospital, he is coldly professional unless he knows that the nurse he is joking with won't take what he says the wrong way."

LEGAL EXPERTS and physician administrators alike agree that discretion and common sense should dictate how we act in various professional settings. Remaining aware of co-workers' sensitivities should help prevent misunderstandings and incidents.

"Health care workers should just do their job without regard to the gender of those around them," said Lebow. "Treat co-workers and colleagues in a way that won't threaten them sexually. It really is just a matter of exercising common sense." ■

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*Table refers to 3-oz, cooked servings.

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- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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Bills advance

(Continued from page 1)

Santiago (D-Chicago), passed the House May 13 by a vote of 116-0. S.B. 602 would require IDPR to receive input from either the licensing or disciplinary board before taking action against individuals holding controlled substance licenses. The bill was written to help ensure peer review and due process in disciplinary proceedings.

Residents and medical students would especially benefit from S.B. 603, which passed May 18. Introduced by Fitzgerald and sponsored in the House by Rep. Frank Giglio (D-Calumet City), the bill would establish a $100 fee for individuals who apply for their medical license within the last 12 months of the three-year licensing cycle. It would ensure that physicians would not have to pay the full fee if they were issued a license during the last year of the renewal cycle. The standard $300 fee would remain the same for all other renewals.

If Gov. Jim Edgar signs H.B. 1974, visiting medical professors will be allowed to demonstrate or perform certain subjects or techniques, in addition to studying them. Passing the Senate 52-1, but awaiting House concurrence on two Senate amendments, the bill would amend the Medical Practice Act of 1987. The measure was sponsored by Rep. Edgar Lopez (D-Chicago) and Sen. J. Bradley Burzynski (R-Sycamore).

ISMS also supported a bill that would award grants from the Illinois Department of Public Health to physicians practicing obstetrics in Illinois' rural designated shortage areas. Introduced to increase the number of OB and primary care physicians in downstate counties, the bill calls for physicians performing OB services in underserved areas to be reimbursed for malpractice insurance costs. S.B. 607, sponsored by Rep. Jack McGuire (D-Joliet) and Sen. Jim Rea (D-Christopher), passed the House May 13.

IN A LEGISLATIVE SESSION in which public health measures made little headway, H.B. 1576 – an anti-tobacco measure strongly supported by ISMS and the American Cancer Society – passed both houses and received House concurrence on a Senate amendment. Introduced by Rep. John Dunn (D-Decatur) and sponsored in the Senate by Sen. Doris Karpiel (R-Roselle), the bill would impose restrictions and prohibitions on tobacco sales to prevent children from smoking or chewing tobacco. Other anti-smoking measures – including a bill introduced on behalf of ISMS and strongly backed by ISMS House of Delegates policy banning smoking in open and closed stadiums – failed to advance this session.

Sponsored by Sen. Judy Baar Topinka (R-North Riverside), S.B. 66 passed both houses and received concurrence on an amendment in the Senate. The measure would amend the Alternative Health Care Delivery Act to add postsurgical recovery care centers as authorized alternative health care delivery models. Under the legislation, IDPH and the Illinois Department of Public Aid would develop reimbursement plans for participating facilities and IDPA would report to IDPH those services provided to Medicaid patients. Facilities would have to be licensed as ambulatory surgical treatment centers or hospitals for at least two years before participating in the program. ISMS House of Delegates policy supports legislation aimed at establishing pilot postsurgical treatment centers provided these model facilities obtain a certificate of need and establish adequate peer review, credentialing and quality assurance structures. An identical bill, H.B. 2287, sponsored by Kotlarz and Topinka, was held in the Senate Rules Committee earlier in the session. ISMS opposed two other identical bills – H.B. 552, sponsored by Rep. David Phelps (D-Eldorado), and S.B. 228, sponsored by Sen. Karen Hasara (R-Springfield) – which advocated creating birthing centers as health care delivery models. The bills, which failed early, did not stipulate whether the facilities would be required to follow American College of Obstetricians and Gynecologists guidelines.

H.B. 1576 – an anti-tobacco measure strongly supported by ISMS and the American Cancer Society – passed both houses.

Also passing both houses was a bill that would amend the Child Passenger Protection Act by requiring all children – even nonresidents – to wear appropriate safety restraints while traveling in Illinois. S.B. 180 was sponsored by Chicago Democrats Sen. John Cullerton and Rep. Barbara Flynn Currie.

TUBERCULOSIS TESTS for schoolchildren would be mandatory in certain areas under S.B. 846, which advanced May 12. Topinka introduced the measure, and Rep. Jack Kubik (R-Riverside) sponsored it in the House. Physicians practicing in areas not designated for the tests could use their medical judgment in ordering such tests.

ISMS took no position on two bills amending the Illinois Public Aid Code, which passed May 12. S.B. 367, sponsored by Currie and Rep. Margaret Smith (D-Chicago), directs IDPA to develop a long-range plan to implement case management services for Medicaid-eligible pregnant women and mothers under age 17.

S.B. 478, sponsored by McGuire and Sen. Thomas Dunn (D-Joliet), received concurrence on a House amendment in the Senate. The original bill called for individuals convicted of public aid fraud to perform community service in addition to any other penalty provided under the law. ■

Rural health care

(Continued from page 1)

board is composed of three ISMS members, all alumni of the program, and three IAA representatives. Randall L. Mullin, MD, a family physician from Geneseo, entered the program as a medical student in 1968. Now he serves as chairman of the RIMSAP board.

"Both my father and grandfather were small-town doctors, and growing up, I saw the special intimacy they had with the communities they served. I wanted to have that type of intimacy, too. The program allowed me to realize my dream," Dr. Mullin said, adding that the program can show the benefits of serving a rural community to students who lack experience with small towns. "Hopefully, the result will be win-win. The town will get the care it needs and physicians can enjoy the comfort of a small-town practice."

The student loan fund now offers up to $20,000 per student over a four-year period, with an annual interest rate of only 4 percent. Because of the program's success, the U of I College of Medicine lifted the limit on the number of students the board can recommend for admission. At the board's last meeting in December 1992 it reviewed 81 applications and submitted 29 recommendations for admission.

Applicants must be Illinois residents, and their applications must include the signatures of their county medical society president or secretary and county farm bureau president. This year's deadline for applications is Nov. 1, and interviewed students should receive responses by Feb. 1, 1994. The board's next meeting is scheduled for July, at which time members will consider coordinating a similar program with the Southern Illinois University School of Medicine.

Dr. Mullin said the program has successfully placed practicing physicians throughout Illinois, and most students who enter the program continue to serve rural areas even after their five-year obligation. "But there is still a lot of work to be done; you can still see many areas crying out for health care. Hopefully, everyone involved with rural health – including the state, the IHA [Illinois Hospital Association], the medical schools – can all get together and be even more aggressive toward solving the problems with access to rural health care."

IN ADDITION to its involvement in RIMSAP, ISMS coordinates a program that sends rural doctors to communities that need solutions to rural health problems. Physician participants in the ISMS rural health speakers bureau address town meetings or smaller groups interested in preventing or resolving health care problems in their communities.

Participating physicians help area residents identify ways to bring quality health care to their towns. The most difficult step is getting started, the speakers say, and the bureau helps communities find additional sources of information and learn ways to initiate a long-term plan that evaluates all the solutions and their costs. The speakers stress the need for members of communities to get together and do the work themselves, without relying heavily on outside sources.

For more information, or to schedule a speaker, contact the ISMS health care finance division at (312) 782-1654 or (800) 782-ISMS. For more information about RIMSAP, contact the ISMS deputy administrator office. ■

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HHS awards

(Continued from page 3)

According to his nominator, Dr. Bailen's office is the only medical clinic in an area in which most of McLean County's low-income residents live.

Described as a kind and concerned physician, Dr. Bailen was lauded by his nominator as the "chief health care advocate for disadvantaged children in his community." She urged others to adopt his concern for the health care needs of children and "promise to carry on his lifelong goal of assuring essential health services for all the children of the state of Illinois."



Amy Rothblatt

Dr. Lumpkin presents the Letter of Recognition for Community Leadership to Dr. Klobutcher at the Chicago ceremony.

An active Ob/Gyn from Park Ridge, Jerome A. Klobutcher, MD, has spent the last four years volunteering at a prenatal clinic in Rolling Meadows. Recipient of the secretary's Letter of Recognition for Community Leadership, Dr. Klobutcher was described by his nominator as the "doctor who always has a smile for both clients and staff." After graduating from medical school and working in private practice, Dr. Klobutcher said he felt as if "something was missing. I had all this training and knowledge; I was in private practice and earning good money; and I felt like I needed to give something back." He called the Cook County Department of Public Health and volunteered his services.

He said that volunteering is not for everyone but that if physicians feel the need "to give something back, to do something," they should consider volunteering. "Give it a try, be open to the potential experience you can gain. I feel my experience has made me grow. There was a personal satisfaction in putting my education into practice to help people who may not be able to afford health care elsewhere."

Awards for Outstanding Community Health Promotion Programs were presented to five projects throughout the state. The Will-Grundy Medical Clinic in Joliet was recognized for establishing a clinic staffed by volunteer physicians, nurses and clerical workers serving area residents who lack access to medical care. Jackson County's "wellness weeks" program, sponsored by the Jackson County Health Department, was recognized for presenting health and wellness education programs to more than 1,000 elementary school children annually.

Other honorees were the Cook County Department of Public Health's HIV Community Prevention Project for conducting a series of culturally sensitive HIV/AIDS prevention workshops for Hispanic families; the Illinois Department of Public Health's Cervical Cancer Control and Demonstration Project for developing a computerized patient registry and tracking system, and bilingual cervical cancer educational materials for West Town Clinic Chicago; and the Rockford Comprehensive Perinatal Care Program, sponsored by Crusader Central Clinic Association, for providing health services, including OB care and parenting and nutrition education for women and their newborns. ■

Americans' lifestyles cost the country billions

[CHICAGO] Healthier lifestyles could be one solution to the U.S. health care crisis, according to messages culled from the AMA study "Factors Contributing to the Health Care Cost Problem." The study showed that one of every four dollars spent on health care is for lifestyle-related illnesses. This costs the country about $171 billion a year.

According to the study, violence, drugs, alcohol and tobacco – along with failure to use seat belts and smoke detectors, reckless recreation and failure to treat diseases such as hypertension – are responsible for an estimated 1 million premature deaths each year. About 500,000 of those deaths result from tobacco-related illnesses alone, which carry an annual price tag of $22 billion. Direct costs for treatment of alcohol-related illnesses total about $13.5 billion a year, drug abuse about $10.6 billion a year, and street and domestic violence another $5.3 billion a year, according to the AMA.

HIV, too, has contributed to escalating health care costs. The AMA study found that AIDS treatments cost the country more than $10 billion in 1992, lifetime care costs for each HIV-infected person topped $100,000, and the projected 1995 cost of providing medical care for HIV-infected individuals is $15.2 billion. ■

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To inquire or apply, please call (612) 347-2277 or send VITA to the Personnel Department, Hennepin County Bureau of Health, 701 Park Avenue South, Minneapolis, MN 55415. VITAE are accepted until further notice.

Pilot City Health Center

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United Way honors Joliet MD

Stanley G. Rousonelos, MD, of Joliet, won the 1993 Outstanding Volunteer Award in the Health and Human Services category for his work at the Will-Grundy Medical Clinic. The award was presented by the Volunteer Referral Service of United Way of Will County.



Dr. Rousonelos

A retired family physician, Dr. Rousonelos was a member of the community task force convened to address the need for such a clinic. After the clinic opened in March 1988, Dr. Rousonelos recruited doctors to donate their time to treat clinic patients. In addition, Dr. Rousonelos himself volunteered at the clinic, which won ISMS' 1990 Non-physician Public Service Award.

Dr. Rousonelos continues to work at the clinic and has provided more than 300 free school physicals in the past year. He was a member of the clinic's original board of directors, served as president in 1991-92 and still sits on the board. Dr. Rousonelos also serves on the ISMS Council on Public Relations and Membership Services.

Virenda S. Saxena, MD, of Burr Ridge, has been appointed chairman of the department of therapeutic radiology at Rush-Presbyterian-St. Luke's Medical Center. Dr. Saxena joined the medical staff of Presbyterian-St. Luke's Hospital in 1967 as an associate attending physician and assistant professor of therapeutic radiology. He served as a major in the U.S. Army Medical Corps from 1969-71 and established the first section of radiation therapy at the Brooke Medical Center at Fort Sam Houston in San Antonio. He returned to the newly established Rush-Presbyterian-St. Luke's Medical Center in 1971 and coordinated the therapeutic radiology residency program at Rush Medical College, where he has been a professor since 1981.

In a random survey of 400 Chicago-area physicians and nurses commissioned by WLS-TV, Chicago's ABC affiliate, Eduardo Madamba, MD, of Chicago, was ranked most often as the "No. 1" physician to whom they would refer their family members.



Dr. Madamba

"I couldn't believe the news when I heard it! I am pleased I was recommended so highly by my colleagues," said Dr. Madamba. A board-certified Ob/Gyn, Dr. Madamba has been on staff at Chicago's St. Elizabeth's Hospital for 13 years. He has served on the hospital's bylaws, surgical case review and quality management committees. He also has served as a member-at-large of the hospital's medical staff executive committee.

The Elmhurst Memorial Hospital medical staff presented John L. Picchietti, MD, of Elmhurst, with its Distinguished Service Award in recognition of his leadership and dedication to the medical profession. Dr. Picchietti is a member of the hospital's board of trustees and board of governors, and is president of the Elmhurst Physicians' Association. He has been a practicing Ob/Gyn for 32 years.

Mary Ann Malloy, MD, of Oak Brook, is one of 10 women honored this year by the DuPage District of the YWCA as an outstanding leader in DuPage County. An internal medicine specialist, Dr. Malloy was featured in an article on women and heart disease in *Today's Chicago Woman* and is a regular medical commentator for WMAQ-TV, Chicago's NBC affiliate.

Through an AMA-sponsored program called Indian Health Service – Project USA, volunteer physicians are sent to American-Indian reservations nationwide. Francis Sun, MD, and Manoochehr Sharifi, MD, both of Waukegan, joined this program to donate their time and expertise to caring for American Indians who have virtually no other access to medical services.

As reported in the *Lake County Medical Society Bulletin*, Dr. Sun said medical care is inadequate on many of the reservations, and if not for volunteer physicians, most residents would travel 200-300 miles for proper medical care. Both physicians agreed the experience was rewarding and have volunteered to go back.

Lawrence Pankau, MD, of Park Ridge, has been appointed medical director of Resurrection Nursing Pavilion in Park Ridge. An internist, Dr. Pankau will evaluate the medical care provided to residents, help develop medical and nursing policies and serve as liaison with residents' personal physicians. ■

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

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CONTRAINDICATIONS
Hypersensitivity to any component of this medication.
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Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Prevastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.
WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.
As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.
Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.
Skeletal Muscle: Rhabdomyolysis with renel dysfunction secondery to myoglobinurie has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporerily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhebdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**
The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occesionally be essociated with myopathy. The combined use of prevastatin and fibrates should generally be avoided.**
PRECAUTIONS
General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.
Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.
Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.
Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.
Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.
Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.
Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)
Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.
Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.
Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.
Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.
In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.
Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.
Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.
CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.
A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.
Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.
The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.
A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.
No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/– mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.
In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.
Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.
Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.
Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).
Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)
ADVERSE REACTIONS
Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.
Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below, also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.
The following effects have been reported with drugs in this class:
Skeletal: myopathy, rhabdomyolysis.
Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.
Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.
Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.
Reproductive: gynecomastia, loss of libido, erectile dysfunction.
Eye: progression of cataracts (lens opacities), ophthalmoplegia.
Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).
Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.
Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interections.**)
OVERDOSAGE
There have been no reports of overdoses with pravastatin.
Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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THE PRAVACHOL® DIRECTION
IN LIPID MANAGEMENT

Effective lipid management doesn't have to be tough

- Improves key lipids — significant reduction in LDL-C[1]
- Excellent safety profile
- Easy for patients — once-daily dosing, well tolerated
- Usual dose: 20 mg once daily at bedtime, with or without food

PRAVACHOL®
pravastatin sodium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

Bristol-Myers Squibb Company

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RENEWAL DEADLINE JULY 31 (PAGE 11)

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Physicians reflect on economic credentialing
PAGE 12



Exchange seminar addresses medication mishaps
PAGE 9

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Economic credentialing issue at a standstill

DEADLOCK: Physician efforts continue to address economic credentialing practices by expanding due process. By Tamara Strom

[SPRINGFIELD] ISMS and the Illinois Hospital Association hit an impasse in negotiations earlier this month over the fate of proposed legislation that would address economic credentialing practices. The bill would codify and expand existing due process regulations adopted under the state Hospital Licensing Act.

Economic credentialing is the growing practice of using economic criteria, rather than clinical competency, to determine medical staff privileges. *AHA News*, published by the American Hospital Association, reported a 1992 survey that was conducted by Loyola University. The survey of 1,965 chiefs of staff found that 60 percent of hospitals use economic data to evaluate physicians for appointment and reappointment.

"ISMS is attempting to protect physicians' due process rights to a fair hearing on adverse hospital credentialing decisions because of outrageous economic credentialing practices," said ISMS President Arthur R. Traugott, MD. "Physicians may not have first-hand experience with economic credentialing, but the threat to

(Continued on page 18)

AMA program helps physicians manage managed care

EDUCATION: Helping physicians adapt to today's changing health care marketplace is the focus of a new educational program. By Gina Kimmey

[CHICAGO] As the role of managed care continues to increase in U.S. health care delivery, many physicians representing themselves and their patients have fewer choices and less control in determining delivery of medical care in this country.

In anticipation of the Clinton administration's upcoming health care reform proposal, the AMA has unveiled a new program to help physicians make sense of today's health

(Continued on page 14)

INSIDE

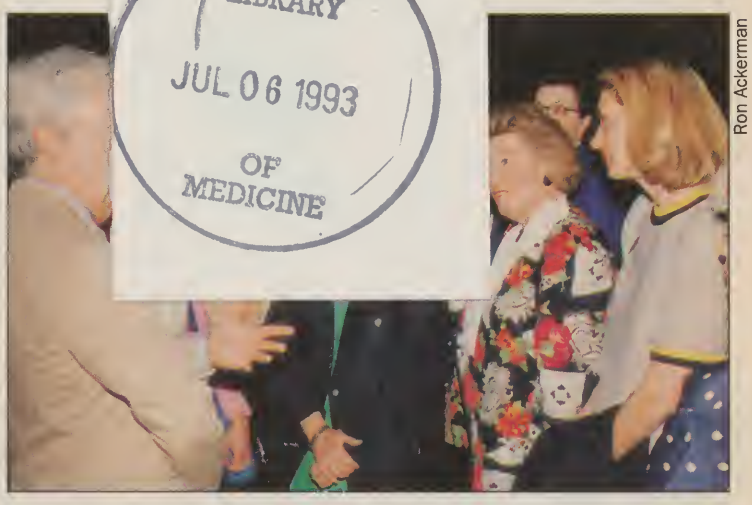
Smoking becomes top priority
PAGE 2



Auxilians attend campaign school
PAGE 5

DEPARTMENTS

News Briefs.....2
Commentary.....6
Members in the News.....8
ISMIE Update 9
Classifieds 15



Ron Ackerman

ISMS AUXILIANS took on the role of lobbyists during their May 25 day at the Capitol. See story, page 5.

Blue Cross implements cost-control mechanisms

PHYSICIAN PARTICIPATION: Changes to Blue Cross' managed care programs reflect the trend toward containing health care costs. By Tamara Strom

[CHICAGO] Several cost-savings measures are among the new managed care plan procedures announced May 26 by Blue Cross and Blue Shield of Illinois. In a letter to physicians, BCBSI characterized these changes as "another excellent opportunity to increase access to managed care for the majority of our customers and your patients." The insurance company provides health care coverage for nearly 2.5 million Illinoisans.

Effective June 1, the carrier will offer a single participating provider contract, replacing the company's separate agreements for individual managed care products. "All providers will also be required to participate in the PPO network," the company's May 26 letter to physicians stated. "This is being done to reduce complexity by allowing BCBSI to simply indicate that a certain provider participates in all product lines, rather than designating that a certain provider participates in some product lines, but not others." Those physicians who sign the new contracts by June 30 will be included in the BCBSI's next PPO provider directory, which will be distributed to subscribers in September.

"Blue Cross and Blue Shield of Illinois realizes that this is a time in which significant changes are occurring in the health care system of the United States and that the pace of change may even accelerate," the physician notices said. "However, BCBSI remains committed to the concept that we should work cooperatively with providers to enhance the provision of high-quality health care services to our members, in a cost-effective manner. Consistent with this commitment, BCBSI is instituting two changes in its physician payment methodologies."

The first payment change limits its direct reimbursement to only BCBSI-participating physicians. As of Sept. 1, the carrier will not pay claims directly to non-participating physicians; instead,

(Continued on page 19)

ANSWERING THE CALL

ISMS ADVOCATES EXPANDED DUE PROCESS IN HOSPITAL CREDENTIALING

One overriding ISMS priority will require physicians' active support when the General Assembly resumes legislative business June 23. That issue is the need for hospitals to provide due process in credentialing decisions about medical staff membership and clinical privileges.

In April, the ISMS House of Delegates adopted policy urging the Society to introduce legislation as soon as possible requiring hospitals to grant physicians economic credentialing protections, including minimum due process. Within days, ISMS was working in Springfield to amend S.B. 398, and members were contacting their legislators to support the bill. The adopted amendment contained elements of the ISMS policy, which codified rules adopted under the state Hospital Licensing Act.

Certain provisions, however, were unacceptable to the Illinois Hospital Association,

(Continued on page 18)

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Smoking issues take priority

ISMS, AMA support cigarette surcharge

[CHICAGO] In the medical community's continuing battle to eliminate tobacco use, ISMS President Arthur R. Traugott, MD; ISMS President-elect Alan M. Roman, MD; and AMA Executive Vice President James S. Todd, MD, registered strong support for a surcharge on cigarettes in Illinois. In letters sent to Illinois legislators, the doctors urged adoption of higher excise taxes on tobacco products. During the legislative session, some lawmakers floated the concept of a 70-cents-per-pack cigarette tax to help finance the state's Medicaid system.

"While the proposal under consideration may involve a seemingly small amount of money for each package of cigarettes, the long-range benefits of effectively encouraging persons to stop smoking are incalculable," wrote Dr. Traugott and Dr. Roman in their joint letter to Illinois legislative leaders. As stated in the letter, numerous studies have demonstrated a direct correlation between higher cigarette costs and a declining number of people who choose to continue smoking.

"As Illinois' legislative leaders, you are in a unique position to profoundly impact the health and well-being of countless Illinoisans," continued Dr. Traugott and Dr. Roman. "The opportunity to effect such change is one we dare not pass up."

Citing that more than 434,000 Americans die prematurely each year from smoking and using other tobacco products, and as many as 53,000 people die from exposure to "passive smoke," Dr. Todd said the AMA is united with Illinois physicians in speaking for the protection of their patients' health on this issue.

"We are firmly convinced that a tax increase will induce many to stop smoking, thus reducing the illness, death and health system costs attributable to tobacco use," Dr. Todd added.

When the General Assembly recessed the first week of June, no final decision had been made on the cigarette tax proposal. ■

Children of smokers at risk for esophageal disorders

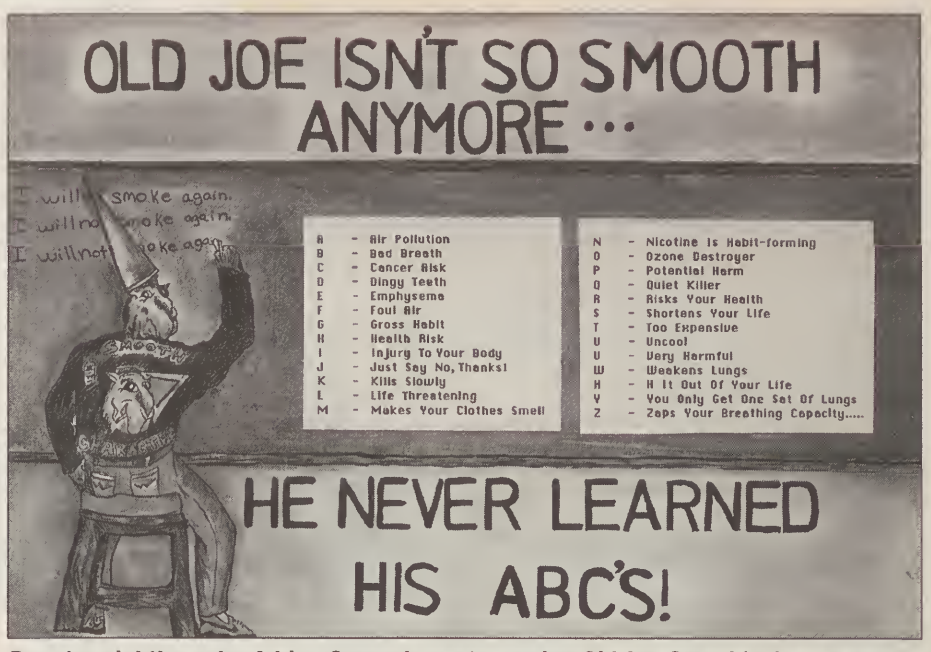
[TORONTO] Children whose parents smoke may be up to seven times more likely to suffer inflammation of the esophagus than children in nonsmoking families, according to University of Toronto researchers. In the 278 cases investigated during the five-year study, scientists found that the risk of esophagitis increased up to six times if one parent smoked and up to seven times if both parents smoked. ■

Students say no to Old Joe

[CHICAGO] "It's crazy to smoke. Why waste your life doing that when you can be doing something better?" asked Adrian Carson, an eighth-grader at Roosevelt Middle School in Decatur, one of three winners of a national anti-tobacco contest called "Say No, Old Joe." The contest was sponsored by the AMA and U.S. Surgeon General Antonia Novello, MD.

"As a physician, I will not stand idly by and allow my children's children and my patients' children to be manipulated for the profit of an immoral tobacco industry," said AMA President John L. Clowe, MD.

To enter the contest, students were asked to submit a letter, essay, poem or poster telling Old Joe Camel, the Camel cartoon spokesperson, why he should stop smoking. Selected from more than 175,000 entries, Carson's poster depicts Old Joe Camel writing, "I will not smoke again" repeatedly on a blackboard, with an A-to-Z list of reasons not to smoke. Winners were selected in three categories – grades K-2, 3-5 and 6-8 – and each received a $200 savings bond and a trip for two to Washington, D.C. The school attended by each winning student also received a $5,000 grant for educational materials or recreational equipment.



Decatur eighth-grader Adrian Carson's poster saying Old Joe Camel isn't so smooth anymore is one of three winners in a national anti-smoking contest.

"The tobacco industry spends millions of advertising dollars trying to encourage young children to smoke. By targeting one of their most visible marketing tools, we hoped to counter the message that smoking is 'cool,'" said Dr. Clowe. Other contest winners were Alice May Davis, a second-grade student from Ramona, Calif., who wrote a letter stating that smoking caused her grandfather to wheeze, and Roger Lukas, a fifth-grader from Ocala, Fla., who painted a poster spoof of a cigarette ad. ■

ACSH releases a guide to harmful tobacco advertising

[NEW YORK] Calling awareness of marketing strategies an important step in disarming the nicotine industry, the American Council on Science and Health released a new report on tobacco companies' attempts to influence young people. The report, "Marketing Cigarettes to Kids: A Consumer Guide to the Harmful Tactics of Tobacco Companies," claims that although the tobacco industry's advertising and promotional programs are supposedly designed to dissuade young people from smoking, these ads actually encourage youths to use nicotine products. The author contends that adolescents are attracted by the lifestyles of the athletic, young models portrayed in cigarette ads, creating false impressions about the safety and desirability of smoking.

"In this country alone, the tobacco industry must attract nearly 2 million new smokers each year to replace those who quit or die prematurely. Most of these replacement smokers are underage youth," said Elizabeth M. Whelan, ScD, president of ACSH. "Almost 5,000 children and adolescents need to be addicted to nicotine every day simply to maintain the size of the smoking population."

According to the report, tobacco companies invest $4 billion a year in cigarette advertising and other promotions. "Tobacco advertising is only economically rational if the industry attracts new young smokers or discourages current smokers from quitting," said Stuart M. Lane, PhD, report author and marketing expert.

Among the marketing tactics discussed are sporting event sponsorships, covert advertising in movies and the cartoon Joe Camel campaign. Lane said the report's purpose is to review ways of safeguarding children's health and protecting them from nicotine addiction and untimely death. ■

PHYSICIAN FACTS

Annual cost of traditional health insurance vs. HMOs

	Traditional insurance cost	HMO cost
New York City metro	$4,852	$3,488
Philadelphia	$4,696	$3,319
San Francisco	$4,531	$3,092
Los Angeles	$4,350	$3,189
Orange County, Calif.	$4,276	$3,124
Chicago	$4,245	$3,088
Cleveland	$4,027	$3,727
Dallas-Ft. Worth	$3,917	$3,330
Atlanta	$3,729	$3,311
Houston	$3,627	$3,575
Seattle	$3,554	$3,092
Minneapolis/St. Paul	$3,347	$2,969

Source: Foster Higgins, 1992. Average per-employee costs, shown above, based on a survey of 2,440 companies nationwide.



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ACOEM takes stand on secondhand smoke

[ARLINGTON HEIGHTS] The American College of Occupational and Environmental Medicine's board of directors has approved a position paper condemning environmental tobacco smoke in the workplace. The group is also asking OSHA to develop standards to regulate secondhand-smoke exposure. The request was prompted by a U.S. Environmental Protection Agency report identifying secondhand smoke as a cancer-causing agent.

In a letter to Acting Assistant Secretary of Labor David Zeigler, ACOEM President Roy DeHart asked OSHA to "eliminate this hazard from the workplace and the community. We urge OSHA to address the health hazard of secondhand smoke separately from other indoor air issues and to make the issue a top priority." Similar letters enlisting support in hastening OSHA's rule-making process were sent to the EPA, the U.S. Department of Health and Human Services, the National Institute for Occupational Safety and Health, and the Secretary of Labor.

In its position statement, the college asked OSHA to mandate that employers develop and implement written policies to provide all employees with an OSHA-defined smoke-free work environment. The college said the policy should apply to "everyone who enters the work environment, including visitors," and should be "clearly communicated to all employees and visitors; [provide for] a phase-in implementation, which includes advance notice to employees; include ongoing training; provide penalties for noncompliance; and provide for voluntary smoking cessation programs." ■

Public willing to pay more to select physicians

[CHICAGO] The ability to select their personal physicians is important to Americans – so important, in fact, that they are willing to pay more for the privilege. That's the message that emerged from a survey conducted for the AMA by The Gallup Organization.

According to the 1993 survey, most respondents would rather pay more for care provided by doctors they choose than pay less for care administered by assigned physicians. Eighty percent said they would pay more to receive immediate care, 74 percent to select hospitals and 54 percent to ensure local availability of state-of-the-art medical technology. About 50 percent of respondents would rather pay private providers directly, while the other half wants to pay more taxes and let the government handle the organization and delivery of health care.

The survey also revealed that Americans believe insurance companies are the single largest source of increased health care costs. Thirty-four percent of those polled identified insurance providers as the primary contributor to escalating health care costs. Other contributors cited include hospitals (22 percent), new drugs and advanced technology (17 percent), and physicians (12 percent). In addition, 88 percent of respondents want the AMA to be a key player in health care reform. ■

Bradley resigns as director of IDPA

[SPRINGFIELD] Robert W. Wright, former deputy director of the Illinois Department of Public Aid, now holds the reins as acting director of the department. On June 1, he replaced Phil Bradley, an appointee of Gov. Jim Edgar. Bradley resigned to take a position as a lobbyist for Share Plan of Illinois.

"We are indeed fortunate to have a professional with Robert Wright's experience and dedication ready to step in," Edgar said. "He has done an outstanding job."

Wright first joined the state government staff as a bond analyst and then became chief of the public assistance division of the Bureau of the Budget. He was named chief of the IDPA Bureau of Hospital Services in 1989 and has since served as deputy administrator in charge of medical programs and deputy director.

In succeeding Bradley, Wright will have a tough act to follow. Among Bradley's accomplishments were downsizing IDPA by 1,000 employees; establishing Earnfare, a program that helps place former public aid recipients in permanent jobs; and launching the Healthy Moms/Healthy Kids managed care program for Medicaid. His 2½-year tenure also included achieving record highs in child-support collections, freezing assets in parents' bank accounts, reporting past-due support to credit bureaus and implementing an expedited hearing process.

"Phil Bradley has served the people of Illinois and this administration well in a very demanding job," Edgar said. "He has helped us to launch innovative programs in the health care area, downsized the department and implemented significant reforms to move individuals from public aid rolls to private sector payrolls."

Before his appointment as IDPA director, Bradley served as director of the Illinois Department of Rehabilitation Services. ■

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REPORT FOR *Illinois Physicians*

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CHANGES IN PHYSICIAN PAYMENT

Blue Cross and Blue Shield of Illinois (BCBSI) realizes that this is a time in which significant changes are occurring in the health care system of the United States, and that the pace of change may even accelerate in the near future. However, BCBSI remains committed to the concept that we should work cooperatively with providers to enhance the provision of high quality health care services to our members, in a cost effective manner. Consistent with this commitment, BCBSI is instituting two changes in its physician payment methodologies.

Effective July 1, 1993, BCBSI will revise its Schedule of Maximum Allowances (SMA) currently in use in two of its managed care products, PPO Plus and Managed Care Network Preferred (MCNP), which is a "point-of-service" product, as a first step to have the SMA migrate more toward the Resource Based Relative Value Scale (RBRVS) physician payment methodology. The current maximum allowance for each CPT code has been reviewed. Allowances for CPT codes related to office visits (E and M codes) and to primary care will, in general, be left unchanged, although some will be increased; however, allowances for some procedure codes, usually related to surgical specialty procedures, will be reduced.

On September 1, 1993, BCBSI will institute a change in physician payment processes which will provide a distinct advantage to those physicians who have signed participating agreements with BCBSI. BCBSI will no longer pay claims directly to non-participating providers, but rather will pay the BCBSI member/patient directly. Participating providers will continue to receive payment of their claims directly from BCBSI, as in the past. For information on becoming a participating physician, call BCBSI's special toll-free number (1-800-538-7560).

BCBSI believes these changes in provider payments will better position both the providers and our members in regard to possible future national health care reform.

(Issue: 06/18/93 - BS)

U of C wins mammography research grant

[CHICAGO] Researchers at the University of Chicago Medical Center have received a $1.4 million grant to develop a computer-assisted system to help detect and classify abnormalities found on mammograms. The grant was awarded by the U.S. Army Medical Research and Development Command.

Expected to reduce the number of breast cancers missed by radiologists, the system would serve as a second opinion, aiding physicians in determining whether lesions are benign or malignant, and whether to order a biopsy. Radiologists would continue to make the final diagnostic decision, however.

Although mammography is currently the best way to detect breast cancer early, the test fails to spot between 10 percent and 30 percent of cancers. In about two-thirds of these false-negatives, a radiologist did not detect a cancer that was present and visible when the mammogram was more closely examined months or years later. In some of these cases, the abnormalities caused by the cancer were subtle enough to escape detection by a radiologist's eye on initial examination.

"Our goal is to find missed cancers. By alerting those who read mammograms when to take a closer look at irregularities on an x-ray, this system should substantially increase the effectiveness and reliability of screening mammograms," said Maryellen Giger, PhD, U of C associate professor of radiology and principal grant investigator.

Work on the system has been under way at the U of C for several years. Although organizations such as the American Cancer Society and the National Cancer Institute have supported the system, the Army grant should speed the process and eventually help make the technology available in a modular system at a reasonable cost, the investigators said.

The federal grant funds became available through a controversial 1992 defense budget amendment diverting $210 million from military spending to support peer-reviewed breast cancer research. According to the U of C, this is the first time Congress has succeeded in tapping military funding for a civilian program. ■

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Manoplax treatment regimen altered

[LINCOLNSHIRE] Boots Pharmaceuticals is alerting physicians who prescribe Manoplax (Flosequinan) tablets for patients with congestive heart failure that a dose of 100 mg per day may cause a significantly increased mortality rate. The manufacturer recommends that dosages be reduced to 50 mg to 75 mg per day. The company is performing an ongoing analysis of the drug.

In a May 21 letter to physicians, Gilbert H. Mayor, MD, senior director of medical services for Boots, states, "In consultation with the Food and Drug Administration, we are continuing the analysis of additional available data from the Prospective Randomized Flosequinan Longevity Evaluation trial."

The drug is prescribed for patients with congestive heart failure who do not respond adequately to digitalis, diuretics and angiotensin-converting enzyme inhibitors.

"This randomized, double-blind, placebo-controlled study was designed to evaluate the effects of Manoplax on mortality in patients with severe congestive heart failure," Dr. Mayor added.

Preliminary study results suggest that a dosage of 100 mg per day is too large for certain patients and a reduced dosage of 75 mg per day has not shown an overall increased death rate. The company will continue to study the 75-mg-per-day dose. ■

Medical student wins service award

[CHICAGO] An Oak Lawn medical student's efforts to expand a pediatric AIDS support program at Rush-Presbyterian-St. Luke's Medical Center in Chicago has garnered a community service award.

James Tess, a sophomore at Rush Medical College, received the CIBA-GEIGY Award for Outstanding Community Service in a June 12 awards ceremony for Rush students. Tess, who served as medical student coordinator for the Rush Pediatric AIDS-Big Sib Program, worked on a fellowship from the Pediatric AIDS Foundation to study the benefits of such a program for HIV-infected children. This summer he will write a paper about his fellowship research.

Rush's Big Sib program pairs medical students with HIV-positive children from Children's Memorial Hospital in Chicago. The students write letters to the children, call them and take them on outings. Tess is a big sib to a 10-year-old who was HIV-infected at birth.

"The program gives these children a permanent friend – someone who's always there for them," Tess said. "We want to help these children grow and develop like other children their age. It's been really rewarding for me." ■

Auxilians convene at the Capitol

LEADERSHIP: A two-day conference helps the ISMS Auxiliary learn the political ropes. By Gina Kimmey

[SPRINGFIELD] Intent on honing their leadership and political skills, the ISMS Auxiliary descended on the state Capitol last month for a two-day summit. The conference, which was aimed at making "political veterans" out of its participants, focused on campaign strategy and leadership training to give the Auxilians the power to promote ISMSA causes.

"Everyone had fun and got into the spirit of the event," said Pam Taylor, ISMSA legislative chairman. "Some of the participants learned new things, while some reviewed what they already knew. Overall, it was absolutely marvelous and a great success."

Participants spent the first day of the meeting in "campaign school." Divided into two opposing sides in a fictional campaign, each group worked to get its candidate elected and gain the financial support of a political action committee. Groups were given a candidate profile, a demographic breakdown and the key issues involved in the campaign, and were instructed to develop an argument to present to a PAC director.

"We reviewed how to set up a campaign and everything that goes into running a campaign. We discussed what government is all about – that politics is government – and how that plays in managing a campaign," Taylor said. "I think it was a wonderful learning experience for everyone involved."

AT THE END of campaign school, Auxilians were updated on the status of economic credentialing legislation in the General Assembly. Guided by ISMS policy, 15 Auxilians headed to the Capitol to lobby lawmakers about economic credentialing of hospital medical staff members. The Auxilians told their legislators about the dangers of economic credentialing, including limiting patients' choice of physician.

"The Auxilians who lobbied found that many of their legislators weren't sure what economic credentialing was; they thought it was caps or peer review, and they were ready to oppose the bill," said Taylor. "But the legislators with whom the Auxilians spoke, who were ready to vote against the bill, changed their minds after hearing the Auxilians' argument."

Taylor explained that Auxilians were encouraged to approach legislators as friends and to "keep their cool. Many of the Auxilians have worked with their legislators before, and it is important to keep that connection. We also suggest that they offer their support and help to the legislators," she said.

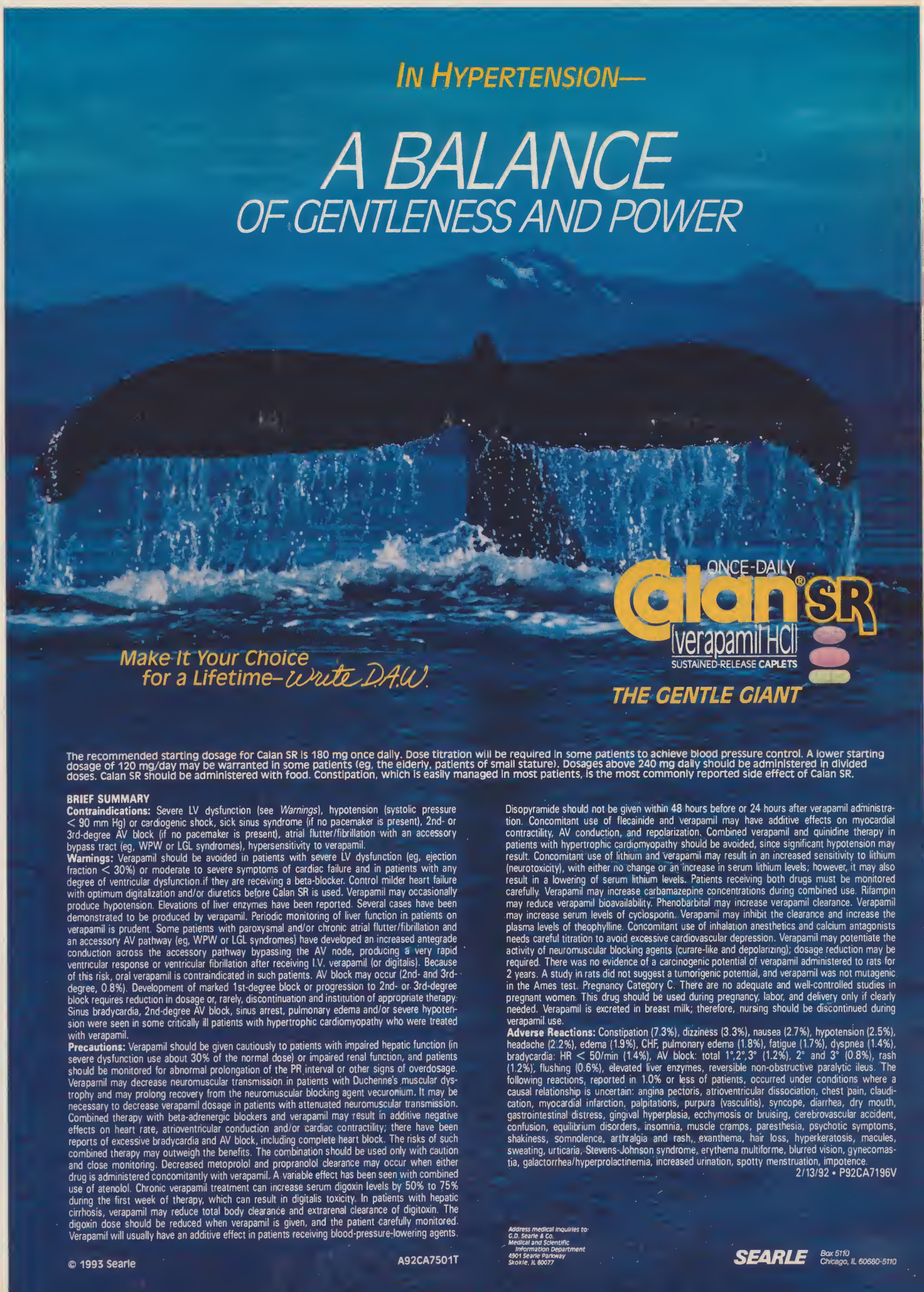
Although some Auxilians lobbied as "seasoned veterans," many were new to the task, and some were returning after several years' absence. "This has probably been one of the roughest years for us in Springfield, and it is not going to get any easier," said Taylor.

"Now more than ever, it is important for more Auxilians and [ISMS] members to get out there and talk to their legislators. We have great lobbyists working for ISMS, but they need more help. We need real people out there; we need that grass-roots support."

DURING THE SECOND day of the summit, Auxilians concentrated on leadership training. Led by ISMSA President Mindy Chadwick, training involved sharing goals and backgrounds and forming one team composed of statewide leaders promoting the ISMSA cause. "We are the only organization working primarily for the physicians and their families. One of my goals as president is to ensure that we are working as a team," said Chadwick.

The main objective of the leadership program was to develop a clearer vision of how county auxiliaries can better support the state, and vice versa, she said. "We were hearing from the membership that they wanted more education; they wanted to have a better understanding of how things worked," she added. The day also included discussions about goal setting and ways to increase membership, another of Chadwick's goals for her presidential year.

"I think the program was very successful. We received very positive feedback," Chadwick noted. "With an election coming up in 1994, it is important for us to focus on getting more friends of medicine in the legislature. Whether you are working on a campaign or with the ISMSA or at the county level, it is imperative that we work as a team toward the same goal." ■



The recommended starting dosage for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food. Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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EDITORIAL

The real problem behind H.B. 1300

Just the word "abortion" provokes controversy. So, by association, any related issue automatically becomes controversial. Recently, with the possibility that H.B. 1300 – the amended parental notification bill – might reach the governor's desk, the media jumped on the story and, in some cases, misrepresented ISMS' position on the bill.

H.B. 1300 would have required physicians to notify the parents of underage women before performing abortions. A Senate amendment to the bill would have allowed courts to waive notification if a judge believed that telling a parent was not in the woman's best interest or that the woman was mature enough to make her own decision. ISMS opposed the bill because it contained a provision that would have severely penalized physicians who performed procedures without notification.

The penalty provision was contrary to existing legislation covering willful failure to comply with the law. Currently, the law requires such noncompliance to be reported to the medical disciplinary board. In addition, the provision would have resulted in three levels of penalties. First, the state's attorneys or attorney general could have brought legal action for imposition of fines of $1,000 for a first violation and $5,000 for each subsequent offense. Second, physicians could have been sued for malpractice, with potentially significant monetary damages. Third, the Medical Disciplinary Board of the Illinois Department of Professional Regulation could have imposed civil penalties and license limitation, suspension or revocation. This penalty system would have been severe and unjust.

ISMS members reacted strongly to the prospect of facing civil and monetary penalties on top of regulatory penalties. The Society's opposition to the bill stemmed from its concern about preserving fairness to physicians while ensuring appropriate discipline of doctors who violate the law.

It's unfortunate that our position on this bill was misconstrued as participation in the abortion debate.

Happy Fourth of July!
Your next regular issue of Illinois Medicine *will be the July 16 edition. In the interim, have a happy and safe holiday.*

PRESIDENT'S LETTER

Depoliticizing parental notification

By Arthur R. Traugott, MD



The law posits physicians as society's 'enforcers' when family communications have otherwise gone awry.

The following letter was written by ISMS President Arthur R. Traugott, MD, in response to an editorial written by Dennis Byrne and published in the May 27 issue of the Chicago Sun-Times:

In a May 27th editorial commentary, the *Chicago Sun-Times* misrepresented the Illinois State Medical Society's position on legislation that would require parental notification before minors could receive abortions. Doctors routinely notify parents to obtain consent when treating minors for any medical condition, and physicians do indeed counsel their teenage patients to talk to their parents about personal health care issues. We are concerned, however, that by imposing extreme civil penalties on physicians, who, for a variety of sound medical reasons, fail to follow the strict letter of this law, we will destroy the very benefits that patient counseling and parental consent are designed to achieve.

House Bill 1300 would place the burden solely and squarely on a physician to notify one of the girl's parents that she was seeking an abortion and would subject a physician to unprecedented civil action for failure to do so, specifically allowing three causes of action: medical malpractice lawsuits, action by a state's attorney and medical disciplinary board action. The law posits physicians as society's "enforcers" when family communications have otherwise gone awry. By the same theory, we should mandatorily fine parents for letting their children have unprotected sex!

Currently, physicians who willfully fail to report suspected child abuse cases are subject to Illinois' medical disciplinary board for review, including mandatory penalties. We strongly believe that issues surrounding a physician's failure to notify parents of a minor seeking an abortion should be handled in a similar fashion.

Your editorial seems to suggest there should be a politically correct quota for the number of disciplined physicians in our state. How high would the number need to be to satisfy your standards? ISMS has worked hard to build high standards for initial Illinois physician licensure on the front end. In combination with a thorough and effective disciplinary process, the low number of disciplines proves that quality control measures are now in place.

The Illinois State Medical Society has worked hard to establish a strong disciplinary process for protecting patients. In fact, we were instrumental in reforming the Medical Practice Act of 1987, which raised physician licensure fees from $100 to $300 to help fund better investigative and disciplinary procedures. In addition, we supported mandatory reporting laws in the early 1980s, which require medical societies, hospitals and medical malpractice insurers to report any adverse actions against physicians to the state authorities for review. These reporting laws trigger investigation by the Illinois Department of Professional Regulation and its medical disciplinary board.

We do not live in a perfect world. Physicians work hard to find, and often anguish over, the best course of care for patients of any age in such difficult circumstances. Politicizing the parental notification issue by forcing doctors to subject themselves to election-driven prosecutions by state's attorneys will not solve the teen pregnancy problems in our state. It will only further drive a wedge between patients, their families, physicians and all of us who want to solve the real problems giving rise to abortion.



"Sound as a dollar? Good Lord."

GUEST EDITORIAL

Preparing for managed care

By Daniel H. Litoff, MD

To prepare physicians for the inevitable scenario of national managed care, physicians must better understand their resistance to managed care. Traditional physician training has focused on general practice, specialties and subspecialties. And the overriding attitude shared by doctors has been the commitment to quality patient care. Doctors have also shared an attitude that they were in sole command of patient care, unhampered by restrictions and regulations imposed by insurers, hospitals and the government.

Previously, physicians had little incentive to control costs. But physicians must now realize the limitations of health care financing, embrace a system of managed care and work to control health care costs. The opportunity to help lower health care costs is very much in doctors' hands. For example, if a procedure can be performed in a doctor's office vs. the emergency room, that is cost control. Ideally, physicians must be the managers of managed care. Doctors must embrace the managed care philosophy of providing cost-efficient, but quality, care for the good of all patients, without bankrupting the system for a select few.

For physicians deciding whether to participate in managed care, one of the most important factors is how it will play out financially. Although physicians participating in managed care are likely to receive capitated fees, chances are they are also seeing more patients. Doctors must not examine what they will earn on each patient or procedure, but how they will be compensated over a year's time.

Of course, there is another side to managed care. Doctors will probably spend more time attending to each patient, because of the network of coordinating specialists, hospitals and other treatments. To satisfy managed care requirements, doctors and their staffs will also confront increased paperwork.

Doctors must face the fact that employers dealing with the rising cost of health care are attracted to the cost controls of managed care systems. So for doctors who want to be part of the system, a natural step is to involve themselves with managed care. The key to a successful managed care practice begins with each physician's education about the benefits of practicing within a managed care system.

The benefits begin with keeping and increasing a patient base that otherwise might switch to physicians who do participate in managed care plans. And the best benefit is continuing to provide quality care in a private practice setting.

It is critical to educate resident physicians regarding managed care. Motivating residents so that they are predisposed to managed care is key to their success. For example, at Michael Reese Hospital and Medical Center, residents caring for HMO patients are required to work in a Faculty-Resident Group Practice, which includes a team of other residents, nurses and attending physicians. Each resident works closely with attending physicians to learn firsthand what managed care entails. For senior doctors who may not embrace managed care systems, effective options include seminars, one-on-one meetings and newsletters explaining how to get the most out of managed care.



A Chicago internist, Dr. Litoff is an ISMS member and treasurer of the Michael Reese Doctors Group IPA.

If doctors assume the responsibility to help patients and maintain reasonable costs, everyone will benefit. Physicians can benefit by getting on the managed care bandwagon before government regulations force them to participate. The new administration is on the verge of proposing radical health care reforms. Doctors must lead this movement by intelligently working with the system, or they will be left behind.

GUEST EDITORIAL

Selling parents on vaccines

By Joan Beck

One inconvenient question keeps being brushed aside in efforts by the Clinton administration to push new immunization legislation through Congress: If the high cost of vaccine, the greedy pharmaceutical industry and cracks in the nation's health care system are responsible for the dismal rate of immunization among preschool children, how come 95 percent to 98 percent of youngsters are vaccinated by the time they start to school?

What's changed – other than the motivation of parents who know their children will not be allowed to start to school until they are immunized? And if parental motivation is the crucial key to getting children immunized, how much good will new legislation do if it focuses on other factors?

The childhood immunization issue was supposed to give an easy, upbeat victory to the new administration. It is dear to the hearts of the FOHs (Friends of Hillary). And it would advance the Clinton agenda of increasing government control over the nation's life and financial resources.

In an effort to ring up quick success, President Clinton and his liberal-activist supporters snowed the nation with a blizzard of dismaying statistics: Only 40 percent of American children have had all recommended shots by age 2. The percentage is much worse in some rural and inner-city areas. American immunization rates for preschoolers fall below some Third World countries. Measles has been making a comeback in the United States, especially among young children. There were 26,000 cases in 1990, including some fatalities. Other preventable diseases may soon be on the rise.

The problem, the administration insisted, is the high and escalating cost of vaccine, driven by the money-gouging pharmaceutical industry. It also blamed the sorry state of the health care system that makes it difficult for poor parents to find doctors to give their children shots and regular medical care.

The Clintons' initial plan focused on the most convenient villain: vaccine manufacturers. The president proposed that the federal government spend $1.1 billion to buy up all childhood vaccines and distribute them free to doctors to immunize children, whether or not their parents could afford to pay for the shots.

The move would have given the federal government new power over pharmaceutical companies and over health care. As the sole consumer of vaccines, drug manufacturers warned, the government could easily ratchet down the price until manufacturers were forced to shift costs to other products, cut back dangerously on research and development on new vaccines or stop making them entirely.

But congressional opponents objected to paying for free vaccines for non-poor children. That, however, was precisely the point some FOHs wanted to make. Donna Shalala, secretary of Health and Human Services, declared, for example, that immunizing children "should be viewed as a basic function of government on par with protecting our water, our air and our food."

She said, "Providing vaccines based on family income would require means-testing. We don't 'means test' the right to public education, to clean air or clean water."

The administration has now worked out a less-expensive compromise with Democrats on legislation that would give free vaccines to youngsters on Medicaid and those whose immunizations are not covered by private health insurance. The legislation would also appropriate some funds to improve public health delivery systems and to help states keep computerized records of children's immunizations.

Vaccine costs have increased sharply along with other health care bills. More shots are now recommended, as new vaccines have been developed. Manufacturers have had to pay a steep excise tax for a federal fund to reimburse families for vaccine injuries to children.

But by itself, free vaccine won't ensure that all young children get the recommended shots at the prescribed age.

Several states already have programs to buy vaccine from manufacturers and give it free to physicians for all children. Some reports say this has increased immunization rates; others find little difference. Medicaid already provides free vaccinations to youngsters it covers. About half of private insurance policies include childhood immunizations.

A key question remains: If parents of 5-year-olds can – and do – find their way through the vaccine system and see that their children get the necessary shots in time for school, why can't – and don't – parents of infants and preschoolers?

There are myriad reasons and excuses. Public clinics can be inconvenient, crowded, intimidating. Some parents resent filling out the required forms or are embarrassed to say they can't. Some fear they could get into trouble if public health officials notice their drinking or drug abuse. There may be language barriers. Some mothers find it difficult to subject a child to a shot they know will hurt and may make him sick for a day or two afterwards. A few are worried that a severe reaction could leave their youngster permanently brain-damaged.

According to reports from some workers who staff public health vans offering free immunizations, some parents are simply too dysfunctional or too unconcerned or too fearful even to bring their preschoolers out to the street where they could get free shots right on their own doorstep.

A few members of Congress have proposed adding incentives to the new vaccine legislation that would move parents of preschoolers to action as the school deadline does. Among the suggestions: Withhold or cut back on welfare payments until children are immunized as scheduled. Or pay a monthly bonus to welfare parents who do keep up with their youngsters' shots. But Congress won't risk keeping welfare money from children who need it.

This issue could have given President Clinton a splendid opportunity to show off his New Democrat grasp of issues and their complexities. Instead, he took the easy, old tactic of blaming big corporations and proposing to throw more money at the problem.

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Members in the News

Aldo F. Pedroso, MD, received the Chicago Medical Society's 1993 Public Service Award. His nominators cited his fund-raising for Casa Central's annual telethons to benefit low-income elderly and homeless Hispanic families. They also noted his advocacy in Washington, DC, to increase federal funding for subsidized housing for the elderly. A retired pathologist, Dr. Pedroso spent most of his professional life serving the community.

He worked as a physician and consultant at Chicago Reed Mental Health Center from 1986 until his retirement in 1989, and served on the Chicago Council on Foreign Relations. Dr. Pedroso also participated in the Urban Health Program at the University of Illinois at Chicago and ISMS' Partners for Health program speakers bureau.

Michael R. Treister, MD, an orthopedic surgeon from Chicago, was recently named chairman of the 1993 Jewish United Fund Physicians and Surgeons Division Campaign at St. Elizabeth's Hospital. The 1993 JUF will work to maintain health care and education for Jewish residents in Chicago and Israel, as well as 50 other countries worldwide. Funds will also be used to pay for the resettlement of Jews from the former Soviet Union and Ethiopia who have recently emigrated to Israel.



In a survey sponsored by WLS-TV Channel 7, more than 400 Chicago-area physicians and nurses identified those health care providers they would recommend to ill family members. **Mohammad Y. Chaudhary, MD**, of Willowbrook, chairman of EHS Bethany Hospital's department of pediatrics, was named one of the top three pediatricians in the five-county Chicago metropolitan area surveyed. Dr. Chaudhary is also an associate professor of pediatrics at Rush Medical College, where he has taught since 1975.

In addition to his work at EHS Bethany Hospital's Family Health Center, Dr. Chaudhary volunteers at the hospital's Well Child Health Fairs, giving children free physical examinations. The health fairs are intended to help improve the health of children on Chicago's West Side by providing immunizations, physicals, hearing and vision tests, and blood lead-level screenings. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

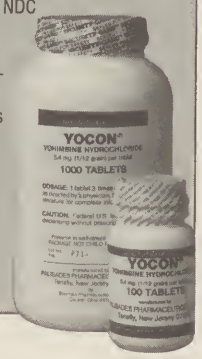
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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MEDICAL LEGAL GUIDELINES

PAGE 10

ISMIE Update

Malpractice Roundup

PAGE 11

Exchange risk management seminar addresses medication mishaps

Panelists advise physicians on the most common causes of medication errors – and ways to avoid them. By Kathleen Furore

What can physicians do to reduce the risk of being involved in lawsuits alleging medication-related negligence? That was the question addressed at the Exchange Risk Management Committee's seminar "Medication Mishaps: Causes and Prevention," held May 19 in Chicago. An additional seminar was held May 20 in Springfield.

Speaking before an audience of about 200 participants in Chicago, mostly Illinois physicians, Jere E. Freidheim, MD, chairman of the Exchange Risk Management Committee and the ISMS Board of Trustees, spoke about the catalyst for the five-hour seminar. Specifically, he cited a continuing increase in the number of claims filed and dollars paid to settle, defend and adjudicate claims involving medication-related allegations.

"We chose this topic based on an analysis of ISMIE's loss data, which shows that since 1985, 9 percent of the Exchange's claims that have closed with payment being made to the plaintiff have involved drug-related allegations," Dr. Freidheim explained. He noted that 27 percent of all the Exchange's medication-related claims have closed with indemnity through settlement or trial award. The average compensation paid for medication-related claims – including losses of $100,000 or more – has reached $226,000, according to Dr. Freidheim.

"We identified the need to alert doctors to problem areas associated with the administration and management of medication, and to provide practical suggestions that will help them avert medical malpractice litigation," Dr. Freidheim added.

Using a case study and discussion format, the program gave participants the chance to review five actual drug therapy cases settled by insurance carriers. Panelists were Michael Hill, MD, a California physician; Olga DeTorres, PharmD, a clinical pharmacist at Mount Sinai Hospital Medical Center in Chicago; and Michael P. Connelly, a partner in the law firm Connelly, Mustes & Schroeder, in Chicago.





Amy Rothblatt

Dr. Freidheim (left) greets attendees of the Exchange's Chicago medication mishap seminar. Program speaker Michael Connelly (above) shares risk management strategies to help physicians avoid medication-related malpractice suits.

Based on the facts in the five cases – as well as on statistics for medication-related claims – the panelists identified the most common reasons for medication errors:

- Failing to take complete drug histories;
- Failing to document prescriptions, patients' allergies, and instructions given to patients;
- Allowing office personnel to renew prescriptions without the physician's approval;
- Failing to instruct patients on the proper administration, risks and side effects of prescribed medications;
- Prescribing drugs that cause injury if used with other prescriptions or over-the-counter drugs; and
- Prescribing the wrong drug or dosage.

Dr. Hill observed that it is no surprise that medication-related malpractice suits are filed. "The [drug] delivery system itself is complicated, and prescribing drugs is a high-frequency event. There are more than 200 million office visits per year, and there are 12 steps between deciding to give a patient a medication and the patient's actually getting that medication." But he stressed that there are ways to prevent such litigation or ensure defensibility if lawsuits occur.

According to the panelists, obtaining thorough medical histories, telling your patients important facts about medications and documenting everything you do and say can reduce the risk of drug-related litigation.

"You have to take a full history and put important findings in the patient's chart. If you don't, as far as the jury is concerned, you didn't do those things," said Connelly.

IN EMPHASIZING the importance of informed consent, Connelly said, "Make sure every patient understands why you've prescribed a drug, what it is and what it's for."

Dr. Hill suggested doctors use preprinted medical instruction sheets listing reasons for taking a specific drug, directions for taking it, contraindications, precautions and side effects.

"From a risk management perspective, we view [using the preprinted sheets] as a safety net," said Dr. Hill. "They give you proof you informed your patient, and [using them] makes patients active participants in their own care."

Keeping abreast of medications, drug interactions and contraindications, and establishing effective office documentation systems were other precautions recommended by the panelists.

Dr. Hill said juries "will always ask if a medication was indicated and if a less toxic medication would have been appropriate." The panelists advised physicians to use the least toxic drugs possible and to "go low and slow" when administering medications.

"Start with the lowest possible dosage and increase it gradually," Dr. DeTorres added.

Connelly stressed that doctors should routinely consult the *Physicians' Desk Reference*. "You have to be familiar with what's in this volume. The *PDR* can be your downfall if you don't look at it, [because] any deviation from the standard of care can be the basis of a lawsuit."

Dr. DeTorres told seminar participants to use pharmacists as resources. "They're aware of new treatment modalities and can use computers to track potential drug interactions." She also advised physicians to simplify drug regimens and to encourage use of one pharmacist, so that medications can be better monitored. In addition, she said that since dangerous drug reactions don't always occur immediately, doctors should ask patients what medications they're taking or have taken, as well as when they stopped taking them.

REGARDING OFFICE procedures, Dr. Hill and Dr. DeTorres emphasized the importance of returning pharmacists' phone calls and documenting all medications and prescription refills. And Connelly stressed the need "to have a mechanism in place

(Continued on page 11)

Percentage of drug-related claims among medical specialties

Internal medicine	18	Pediatrics	4
General practice	9	Orthopedic surgery	4
Ob/Gyn	7	Radiology	3
Anesthesiology	5	Dermatology	3
Family practice	4	General surgery	3

Source: Illinois State Medical Inter-Insurance Exchange

Retention of physician records explained



In Illinois, there is no statute of limitations on retaining physician medical records. But physicians should follow these guidelines:

• Physicians should retain medical records for the longest duration prescribed by the applicable statute of limitations. In Illinois, that would be four years in most instances, according to the statute of limitations on damages. If the records are for an existing and continuing patient, the four-year period begins running from the time that patient ceases being the physician's patient. If the patient is a child, physicians should keep records for eight years, unless the child continues under their care.

Nevertheless, many defense attorneys recommend that records be retained indefinitely because ready access to records facilitates defending a lawsuit. However, retaining the records provides information that must be disclosed if requested; if the records are not retained, that information does not have to be produced. Therefore, using the statute of limitations as a guide serves physicians best. (These guidelines also apply to those records retained under the Sexually Transmissible Disease Control Act.)

• Although the X-ray Roentgen Photographs Act applies to hospitals, physicians should also keep x-rays up to the longest applicable statute of limitations. For x-ray roentgen photographs, that would be five years unless the statute of limitations on damages exceeds the five-year time period, such as in the case of a minor. If litigation is pending before the five-year mark, physicians must keep the film for 12 years from the date it was produced or until they are notified that the case is concluded.

• The statute of limitations dictates that the period of limitations does not begin running for those individuals who have permanent disabilities or are incarcerated, until the disability is removed or the person is released from prison. Moreover, the Mental Health and Developmental Disabilities Confidentiality Act dictates that damages may be brought against physicians for care they deliver to patients who are covered under the Act at any time. Therefore, legal opinions state that the medical records of individuals who have a legal disability, including a mental health disability, or who are incarcerated, should be retained indefinitely.

• Provisions in the National Childhood Vaccine Injury Act of 1986 dictate that as of March 1988, all immunization records must be retained indefinitely.

• Medicare and Medicaid records must be retained for five years.

• The U.S. Occupational Safety and Health Administration requires employers to preserve and maintain an accurate record of all occupational exposures to bloodborne pathogens. This medical record must be kept confidential and maintained for at least the duration of workers' employment, plus 30 years. This requirement is subject to change.

The guidelines listed previously do not apply to records that fraudulently conceal the cause of an action. In such cases, records must be retained indefinitely, because the action could begin any time within five years after the person entitled to bring the action discovers that he or she has such cause. In addition, physicians are urged to retain any medical records involved in a malpractice claim indefinitely.

RECOMMENDATIONS FOR retaining other physician office records vary.

• Patient account records, such as invoices and correspondence, need not be kept for more than one year, once they are paid or acknowledged.

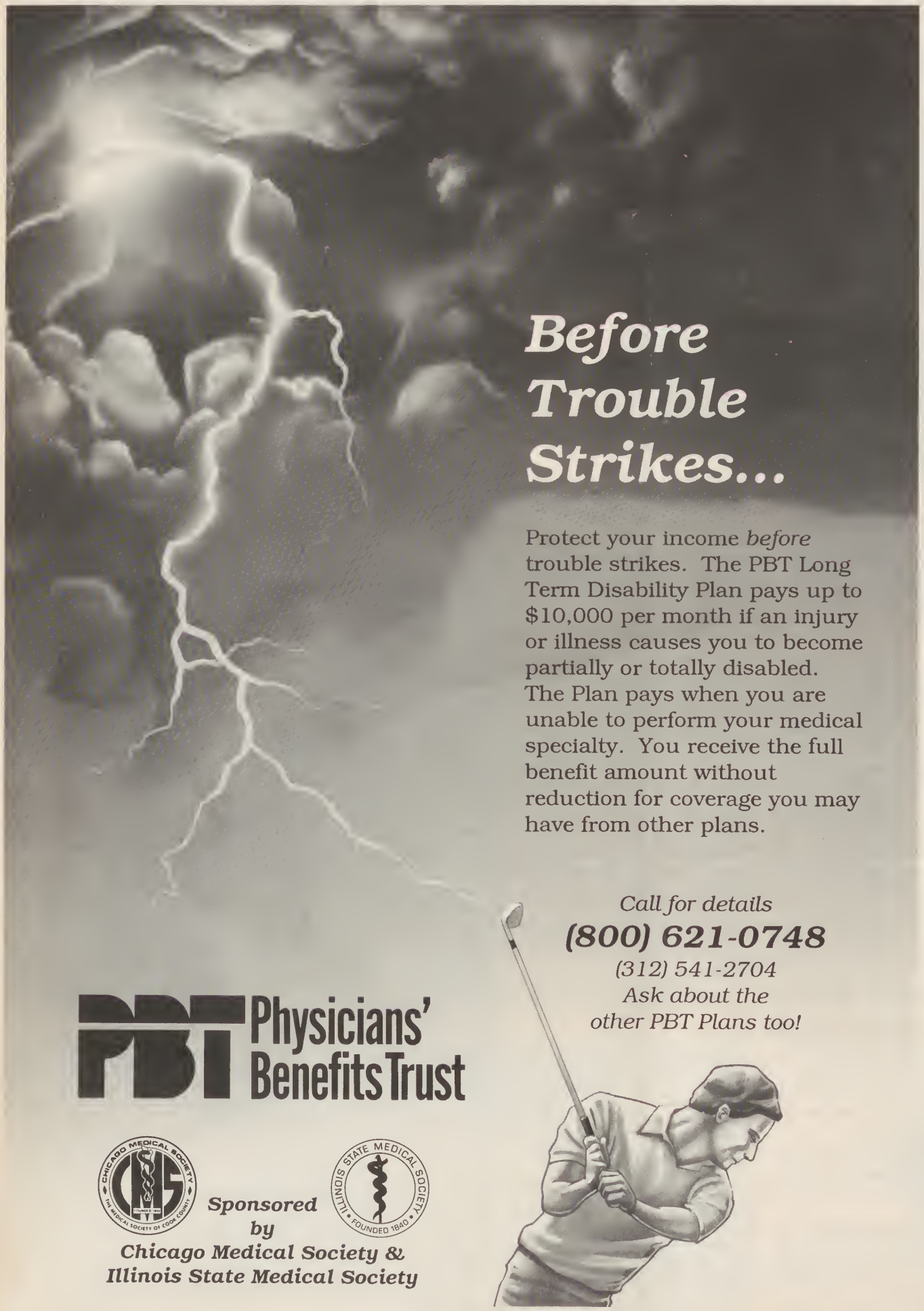
• Appointment books should be retained indefinitely.

• Personnel records, including payroll records, must be kept for at least three years, according to the Fair Labor Standards Act. The IRS mandates that records for payments made to various government entities be kept for five years. Physicians are advised to keep employee benefit program records permanently.

• Tax documents in which payments for services are recorded, tax returns and other tax documents should be retained indefinitely because there is no statute of limitations for the government's review of such records if an individual failed to file a return or is suspected of fraud. However, the IRS must generally challenge the data filed within three years of the due date or the date on which the return is actually filed.

• Triplicate prescription copies should be retained for two years, according to requirements of the Illinois Department of Alcoholism and Substance Abuse; pharmacies must keep the forms for five years.

(Continued on page 11)



MALPRACTICE ROUNDUP

Lack of follow-up increases liability

As reported in *Claims RX*, a publication of the NORCAL Mutual Insurance Co., a reliable follow-up system that organizes and tracks the flow of patient information is essential for any medical office. In one case, a physician was sued for delay in diagnosis and treatment because his office follow-up system failed and he was never informed of test results.

The patient saw the physician because of flu-like symptoms and asked to be tested for HIV. The physician reluctantly agreed, saying the patient wasn't in a high-risk group, so it was unlikely she had contracted the virus. He told the patient he would call her with the results, but since there was little chance of infection, she shouldn't worry if she didn't hear from him.

The test results arrived in the office, but the physician never saw them. When the patient didn't hear from her physician, she assumed she was HIV-negative and didn't check on the results. One year later, she returned to the physician complaining of recurrent yeast infections and commenting that she was glad she was HIV-negative. The physician said he did not recall having tested her for HIV, but when he checked her file he found the test results showing her to be HIV-positive.

The core of this case was the system breakdown in the physician's office. A complete system would have tracked the test results through the office instead of just indicating to the nurse that they had returned from the lab. A follow-up system should include tracking of test results, referral to specialists, follow-up appointments, routine follow-ups and telephone calls to the patient. In addition, all of these steps should be documented.

If patients are harmed because of inaction or delay by physicians or their office staff, the result could be allegations of failure to diagnose, delay in diagnosis or delay of treatment. For information about office follow-up systems, contact the ISMIE risk management department at (312) 782-2749 or (800) 782-ISMS. ■

Hospital liable for anesthesiologist's actions

A hospital was found vicariously liable for the actions of a contract anesthesiologist, according to a case reported in *Hospital Risk Management*. During surgery to remove a cyst from a patient's femur, the patient lost 30 percent to 40 percent of her total blood volume, experienced cardiac arrest and died. The hospital relied on a commonly used method of monitoring blood loss by which nurses weigh the blood absorbed by sponges used in the operation, keep a running tally and relay the information regularly to the attending anesthesiologist. The anesthesiologist testified that the nurses did not properly communicate blood-loss information to him and that he kept a mental tally based on his own estimates.

The trial court ruled against the hospital, based partly on the plaintiff's expert witness' testimony that the nurses' behavior deviated from the required standard of care. The court also ruled that interviews with medical personnel involved in the surgery, conducted by the hospital's risk management director, were not privileged information because they contained primarily factual statements and did not include the risk manager's comments or analysis. The court ordered the hospital to provide the information to the plaintiff.

The article points out that hospitals must notify patients that contract employees, such as the anesthesiologist in this case, are not agents of the hospital and that patients may choose other health care providers. In addition, any written summaries following an incident that could result in a lawsuit should be prepared by an attorney, if possible, as part of the evaluation of the incident. ■

Record retention

(Continued from page 10)

In general, these guidelines also pertain to record retention for physicians who close or relocate an office, or die. In situations in which records must be maintained indefinitely, such as mental health records, vaccinations or incarcerations, no action can be taken once a physician passes away and the physician's estate is closed. If a practice is sold, liability on retention of records is usually transferred from the seller to the buyer, pursuant to the contract terms. Physicians are not required to invoke extraordinary measures to notify their patients when closing a practice; a letter or publication should be sufficient.

THERE ARE NO LEGAL mandates about how physicians should purge medical records, x-rays and mammograms once these records are ready to be destroyed. To maintain confidentiality safeguards, shredding or burning the records is suggested.

For specific guidelines, see the ISMS brochure "A Physician's Guide to Medical Record Access and Retention." ■

Editor's note: This is part of a series on medical-legal issues written by the ISMS Medical Legal Council. These guidelines do not necessarily represent ISMS policy. They address legal concerns that physicians commonly express to ISMS and are intended to serve as only a guide for physicians, not specific legal advice.

DON'T FORGET TO RENEW YOUR LICENSE

All physicians licensed to practice medicine in Illinois must renew their medical licenses by July 31. Failure to do so could subject physicians to disciplinary action by the state Medical Disciplinary Board and loss of their Exchange liability coverage for the time they practice without a valid license. By now, physicians should have received a packet from the Illinois Department of Professional Regulation containing the necessary forms to complete the renewal process. Physicians who have not yet received the forms should contact the department at (217) 782-0458. ■

Medication mishaps

(Continued from page 9)

to chart calls and responses, and make a record of anything you do by phone."

Finally, the panelists recommended that physicians exercise caution when treating other physicians' patients. "Take the patient's history as it relates to the condition you're treating," said Connelly. "Be able to tell what you did, why you did it, what you prescribed and how the patient was when [he or she] left. And if your standard of care is different from that of the primary physician, use your standard of care or don't treat that patient. When covering for another physician, make sure you cover for yourself, too."

PHYSICIANS SHOULD write neat and detailed prescriptions, according to the panelists. Dr. DeTorres advised using standard abbreviations in writing prescriptions, listing the maximum rate at which a drug should be administered, being aware of sound-alike drugs and watching use of decimal points.

"Write out 'one hundred milligrams,' so that there's no chance of [someone] misreading [what you wrote]," Dr. DeTorres continued. She added that in some cases – such as those involving chemotherapy drugs – "the difference of a decimal point can kill your patient."

In addition, Dr. DeTorres advised doctors who are entering medications on a blank sheet of paper to add each hospitalized patient's name and room number. She said physicians should also encourage patients who have experienced adverse drug reactions, especially severe ones, to wear Medi-Alert bracelets.

Cassette tapes of the seminar "Medication Mishaps: Causes and Prevention" are available from the Illinois State Medical Society for $33, plus $3.50 shipping and handling. To order the three-cassette package, mail your payment to: First Tape, Inc.; 770 N. LaSalle St.; Suite 301; Chicago, IL 60610. To place a phone order, call (312) 642-7793; or fax your order to (312) 642-9624. ■

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ASPEN

ECONOMIC CREDENTIALING

Reflections on a tough issue

Physicians debate the consequences of allowing hospitals to continue economic credentialing practices.

BY ANNA BROWN



John McNulty

DENNIS M. BROWN, MD

From a Loyola University study reporting that 60 percent of hospitals are involved in economic credentialing of physicians to ISMS' attempts to codify due process in credentialing, the issue has come to the forefront in medicine recently. Fearing repercussions from hospitals, many physicians are reluctant to speak publicly about the pressure to bring in paying patients or risk losing medical staff privileges.

As directed by new ISMS House of Delegates policy adopted in April, the Society went to the General Assembly with its fight for physicians' rights to due process in hospital credentialing decisions. Although the legislation was at an impasse when the session recessed the first week of June, the proposals contained in ISMS-supported S.B. 614 would protect physicians' rights and help ensure patients of the highest-quality care.

Six Illinois physicians shared their views on how medical staff members can protect themselves from economic credentialing and what the future may hold if no changes are made.

AS MANAGED COMPETITION increases, so will economic credentialing, predicted William E. Kobler, MD, a Rockford family physician who serves as chairman of the ISMS Hospital Medical Staff Section Governing Council and ISMS 12th District trustee. Dr. Kobler said many physicians are so busy that they haven't noticed that economic credentialing is already occurring at their hospitals. "We need to make sure physicians are allowed due process."

Physicians should check the current medical staff bylaws at the hospitals where they have privileges to determine whether they address economic credentialing issues. "Some do, and some don't," Dr. Kobler warned. "Make sure you know what they say. This is a new legal area, and you're not a lawyer."

According to Dr. Kobler, physician credentialing should be driven by hospital medical staffs. "These are medical professionals. Hospital administrators don't have the qualifications or the right to credential. It's not an economic issue for medical staffs. They are concerned solely with quality and provide peer review.

"This is a complicated issue," he added, "and we're only beginning to see the surface of what could happen." He recommended that physicians encountering credentialing problems work with their medical staff organizations and contact ISMS, HMSS and the AMA for help, if necessary. They should also obtain legal counsel.

The main cause of economic credentialing problems for physicians is that hospitals and medical staffs have no

ECONOMIC CREDENTIALING

John McNulty



ARNOLD A. GUTMAN, MD

agreed-upon guidelines for developing physician-specific data, according to Dennis M. Brown, MD, immediate past chairman of the ISMS-HMSS Governing Council and a new ISMS Third District trustee. "Hospitals can and do generate productivity data, which can be constructive."

If a hospital is losing money because of a physician's admitting practices, hospital officials could approach the doctor in a nonthreatening, educational manner, Dr. Brown explained. In this way, physicians could "self-correct" their practices. "The problem is, if doctors don't meet economic standards, they are simply not reappointed."

That's why physicians have been at odds with the Illinois Hospital Association, he said. "But the problem will not go away, law or no law. Doctors and hospitals have to agree, and right now the swords are drawn.

"Ultimately, we may end up with some type of arbitration entity from the state," he continued. "We need to work together toward a compromise. It's not an irreconcilable issue."

Dr. Brown agreed that economic credentialing could increase under a Clinton health care reform package. "Managed care could be ripe for abuse."

A SPRINGFIELD CARDIOLOGIST is personally aware of examples of economic credentialing in his area. Brian D. Miller, MD, of Prairie Cardiovascular Consultants, said he knows of physicians whose practices have been "ripped away for no other reason except economics.

"Many physicians are unaware of what's going on, because they are too busy practicing medicine to see what's happening in the back rooms," Dr. Miller said.

"Our voices are in direct competition with hospital administrators and their outside counsels. Their decisions become irrevocable; then it's too late."

Dr. Miller explained that in central Illinois, hospital administrators have tried to usurp or remove credentialing privileges from practicing physicians. "They surreptitiously change hospital staff bylaws under the auspices of doing physicians a favor by removing hassles," he said. Once the bylaws are changed, the hospital may "use its power to eliminate doctors from the medical staffs." The situation will worsen, Dr. Miller predicted. "Physicians across the state are meeting with very hostile hospital administrators."

John F. Schneider, MD, a Chicago internist who serves as chairman of the ISMS Third Party Payment Processes Committee and as vice chairman of the ISMS-HMSS Governing Council, said, "I feel strongly that hospital medical staffs have the responsibility to develop bylaws and negotiate with hospitals on how they expect to be reviewed by the hospitals. The misfortune is that doesn't happen," which prompted ISMS' legislation aimed at ensuring due process.

"Action is being taken by hospitals without interaction with medical staffs," he added. "But if medical staffs had done what they should have been doing" – developing strong bylaws – "it wouldn't have come to this."

Dr. Schneider explained that hospitals must protect their interests, but so must physicians. "Success under reform will require both parties' working together. They'll have to sit down and negotiate, and both sides may have to give up something."

Arnold A. Gutman, MD, is an allergist who has had no personal experience with economic credentialing practices, but represents allergists and immunologists in his position as president of the Joint Council of Allergy and Immunology. He stressed that although he has not seen any problems at Highland Park Hospital or other hospitals where he holds admitting privileges, he speaks for members of the Joint Council who have had medical staff privileges reduced or revoked.

"Economic credentialing can do our specialty a great deal of harm," Dr. Gutman said, explaining that allergists and immunologists often admit fewer patients than do other specialists. The Joint Council takes the position that economic credentialing is a potential problem that physicians should understand. "We don't want to see it become prevalent," he said.

Dr. Gutman explained that credentialing problems affecting allergists have mostly occurred in other states, such as Texas and California, and he has seen no cases in the Chicago area. However, he said he is concerned about the possibility.

Allergists and immunologists subjected to economic credentialing would be prevented from maintaining hospital staff membership, Dr. Gutman noted. This eliminates networking possibilities between hospitals, limiting institutions' access to patients. Physicians in other low-admitting specialties, such as dermatology and psychiatry, could also be hit hard, he said.

"My function [as president of the Joint Council] is to advise members that this is a consideration," Dr. Gutman said. "They should not allow themselves to be subjected to economic credentialing without a fight."

Recently, the Joint Council's newsletter published steps physicians should take to limit the possibility of credentialing problems and to put physicians in a better position if they are subjected to economic credentialing. Dr. Gutman said physicians who don't admit large numbers of patients should become well-known within hospitals and participate in continuing medical education programs. Physicians can become familiar faces around hospitals by attending meetings, becoming active in medical staff activities, raising funds for the hospital and giving lectures.

"We've been hearing about people in our specialty having their credentials challenged for the past three years, although not necessarily for economic reasons," Dr. Gutman said. "We see economic credentialing as a potential threat to patient access, as hospitals begin to network and as health care reform and managed care develop."

ADDRESSING THE CAUCUS of Women Legislators in Springfield during the legislative session, Janis M. Orlowski, MD, a Chicago nephrologist, helped ISMS

(Continued on page 14)

K.C. Keefer



WILLIAM E. KOBLER, MD

Reflections

(Continued from page 13)

make a case for advancing legislation to institute due process in physician credentialing. "My concerns are that economic credentialing will prevent or discourage physicians from taking higher-risk patients," said the Chicago Medical Society trustee and vice chairman of the CMS Council. Dr. Orlowski said hospitals will discourage physicians from treating patients who have complex ailments or require longer hospital stays, especially when they may not have complete insurance coverage.

Dr. Orlowski said she knows of a geriatrician who saw only nursing home patients on public aid. "These patients had no family to care for them. They couldn't go home, so their hospital care was longer. The physician who saw these patients was discouraged from caring for them. That [kind of] physician gets a bad name."

Despite the fact that relatively few physicians have lost their privileges for economic reasons, Dr. Orlowski said physicians are "definitely feeling pressure" from hospitals. She said that many people, including physicians, are uninformed about how economic credentialing would affect them. But they "should be leery" of this kind of practice." ■

Managed care

(Continued from page 1)

care marketplace. "Medicine in Transition: Managing Change in a New Environment," is an integrated educational program that will broaden physicians' understanding of how managed care works and help them determine how they can best fit into a managed care structure.

"'Medicine in Transition' will educate physicians about health care system reform [and] their practice options, and how they can best function in the managed care arena," said James S. Todd, MD, AMA executive vice president. "[It] is not intended to be a tacit endorsement of managed care as the only or most appropriate means of providing care. It simply acknowledges managed care as a growing reality in the health care marketplace and attempts to give physicians the resources to play a leadership role."

According to Kirk Johnson, AMA general counsel and senior vice president, the program aims to rectify the imbalance in the health care delivery system. "We need to even the playing field and provide physicians with the knowledge and resources that the hospitals have had for years. This type of resource has never been available for physicians before."

Denise Andresen, program coordinator, said the program was created to be educational and provide physicians with practical, user-friendly information. On the basis of the premise that different people learn in different ways, the program consists of four varied components. The first is a four-part series about managed care airing on CNBC. "Managed Care and Your Practice" will air June 19 and 20, followed by shows on July 10 and 11, and 24 and 25.

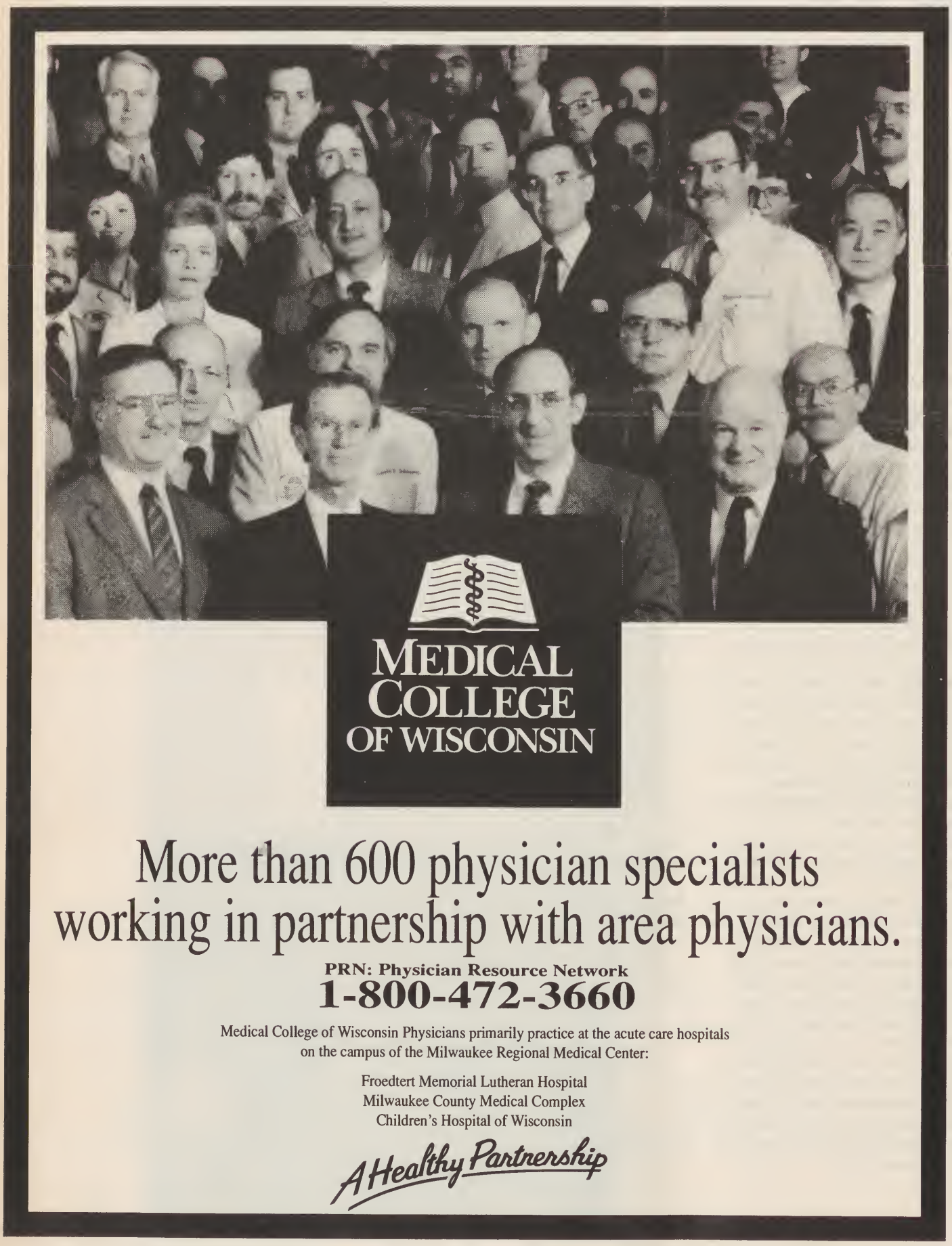
"Doctors' Resource Service: A Managed Care and Health Care Reform Information Series" is a nine-part series of books, videotapes, audio cassettes and newsletters. It aims at providing its subscribers with an in-depth understanding of the workings of managed care, physicians' rights and options and the legal implications of working with a managed care organization.

The third component is a series of physician workshops on managed care. The first workshop, "Managed Care: Strategies for Change," will give physicians the necessary tools to assess their medical practices and local practice environments. Andresen said the AMA hopes state and specialty societies will co-sponsor the workshops. Workshop developers retained the advice of managed care and education experts. "Each workshop will be tailored specifically to the area where it is conducted," said Andresen. The idea is that a physician practicing in an area where 80 percent of the care is delivered through a managed care system will need different strategies than does a physician in an area with only 20-percent managed care.

Since physicians don't generally retain lawyers and consultants the way hospitals do, the AMA has also developed a physician advisory network. "A physician will be able to call an 800 number, tell us what [he or she] needs, and through our data base, we will provide the physician with four or five matches. The doctor can then choose [a consultant] from that list," said Andresen. The program will also include a "peer review" system to track the consultants' progress and ensure that appropriate matches are being made.

The need for the network became evident over the past year as the number of calls from doctors seeking help increased to several per week. "[The AMA] staff is not as expert as the people on this list. We can't give the level of help individually that this network can provide," said Johnson.

For more information about the program, call the AMA at (800) 262-3211 and ask for department HP. ■



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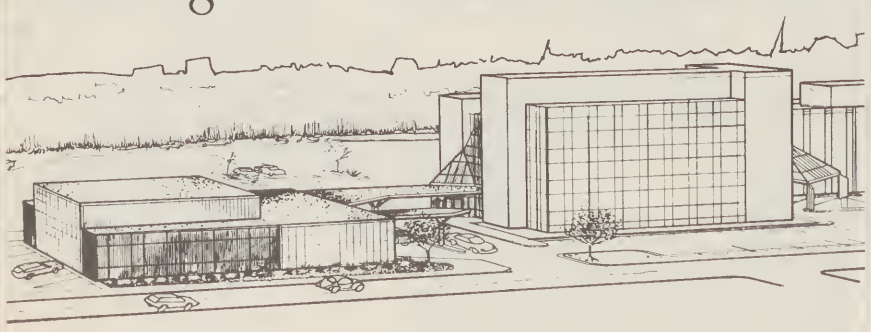
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"Issues in Primary Care," Sept. 17-18, Landmark Inn Resort and Conference Center, Egg Harbor, Wis. Contact: Marshfield Clinic, Office of Medical Education, 1000 N. Oak Ave., Marshfield, WI 54449; (800) 782-8581, ext. 5207.

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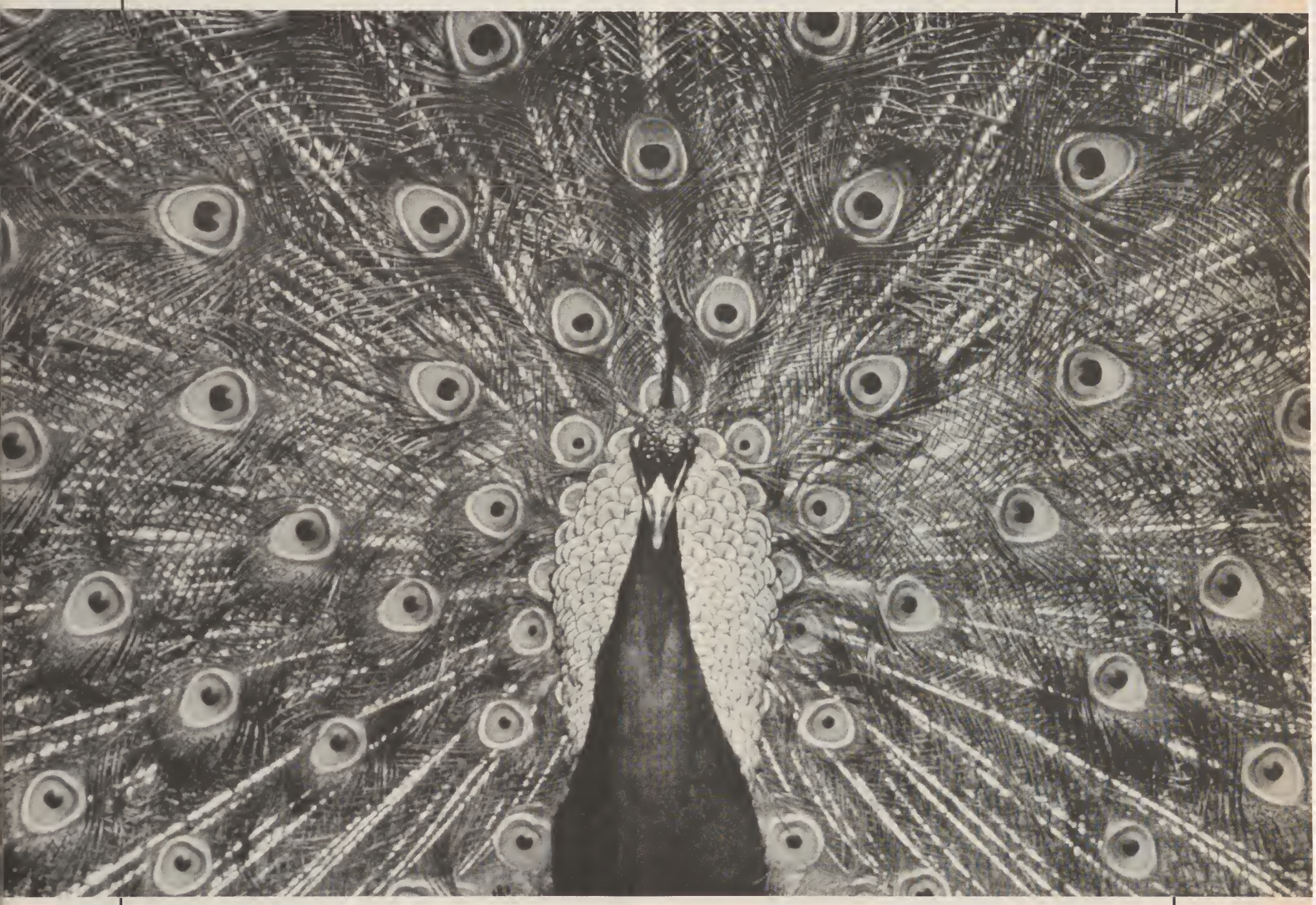
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ISMS advocacy

(Continued from page 1)

so House of Representatives leaders requested that ISMS and IHA negotiate a compromise. The Society did compromise, reducing the delay in the effective date of nonrenewal or limitation from 180 days to 60 days. In addition, a provision was deleted that would have provided physicians with a legal cause of action for restraint of trade. ISMS also consented to allow hospital governing boards and medical staff to jointly decide the composition of hearing panels that would consider adverse credentialing decisions. A clarification was added that a physician could be immediately suspended without a hearing when the safety of patients is endangered. These concessions and several minor changes have been amended onto S.B. 614. Physicians would be afforded minimum due process, including a fair hearing for any adverse decision based substantially on economic reasons.

It is vital that members contact their legislators in support of S.B. 614 and expanded due process in physician credentialing.

This bill would require physicians who experience adverse decisions to be notified of the economic and noneconomic reasons for those decisions. In addition, it would provide that any economic-based decisions regarding current medical staff members' clinical privileges be reported to the Illinois Health Facilities Planning Board. Finally, it would require the Health Facilities Planning Board to complete a study of economic credentialing by Jan. 1, 1996, with periodic updating.

In spite of the extensive ISMS compromises that have been made, IHA is pushing to limit the range of due process procedures and lower the current level of protection. However, ISMS cannot compromise further without sacrificing members' best interests. There is a good chance that S.B. 614 will be considered when the legislature reconvenes. So, once again, ISMS members will have an opportunity to help get a critical bill to the governor's desk.

"Personal contact with physicians is always the best way for those who make the laws to get a clear picture of our main mission. In this case, our goal is to protect physicians while providing our patients with free choice, continuity of care and quality care," said ISMS President Arthur R. Traugott, MD. "We have negotiated and compromised as much as possible on this issue, which is reflected in S.B. 614. It is vital that members contact their legislators in support of S.B. 614 and expanded due process in physician credentialing." ■

State regulations include due process

ISMS is seeking to codify and expand due process procedures and accreditation standards for credentialing decisions already included in rules adopted under the Illinois Hospital Licensing Act, according to a 1993 ISMS legal opinion on the hospital medical staff credentialing process.

Illinois Hospital Licensing Act rules state that medical staffs must create "written procedures relating to the acceptance and processing of initial applications for medical staff membership, granting and denying of medical staff reappointment and medical staff membership or clinical privileges disciplinary matters," according to the ISMS legal opinion.

The opinion also cites hospital licensing rules that require any procedures related to physician evaluation for staff membership to grant current medical staff members at least the following:

- Written notice of an adverse decision by the governing board;
- An explanation and reasons for an adverse decision;
- The right to examine and/or present copies of relevant information, if any, related to an adverse decision;
- An opportunity to appeal an adverse decision; and
- Written notice of the decision resulting from the appeal. The procedures for providing written notice shall include time frames for giving such notice.

JCAHO standards specify that hospital governing boards make final credentialing decisions based on recommendations from the medical staff. JCAHO also mandates that institutions adopt mechanisms for addressing adverse credentialing decisions and that these mechanisms "*include a fair hearing and appeal process.*"

ISMS' proposed codification of due process procedures contained in S.B. 614 only modifies the hospital licensing rules by adding these requirements:

- A detailed written response specifying the reasons for any adverse decision, including economic reasons.
- Adoption of the JCAHO standard of a fair hearing for current medical staff.
- A 60-day delay for current staff members prior to implementation of an adverse credentialing decision based on economic factors. Allowance for immediate suspension of staff privileges, without a hearing, based on quality of care concerns. ■

Economic credentialing

(Continued from page 1)

all physicians is real. Currently, physicians do have the right to appeal these decisions, but the appeal process is not necessarily effective or thorough. Our efforts to pass legislation this spring have centered on standardizing the hearing process to ensure all physicians have access to a fair hearing to address adverse decisions."

Although ISMS successfully amended S.B. 398 to include language ensuring due process, that bill stalled when House of Representatives leaders requested that the Society and IHA negotiate a compromise. The two organizations discussed several changes that ultimately were amended onto S.B. 614. However, they were unable to reach a compromise.

"Unfortunately, IHA was not willing to extend due process to all physicians regarding credentialing decisions, a point that ISMS considers essential," Dr. Traugott said. "We think it's imperative that physicians have an established avenue to follow to discuss adverse medical staff membership and privilege decisions fairly and reasonably."

Some provisions for due process in credentialing decisions already exist in state hospital licensing regulations, Dr. Traugott said. (For more specific information, see "State regulations include due process" above.) However, because no uniform procedures exist, he said a physician's only recourse when facing loss of clinical privileges may be sending a letter to the medical staff or the hospital governing board. A physician may not have an opportunity to comprehensively present his or her view regarding the adverse decision.

Dr. Traugott said ISMS is proposing only the addition of requirements that hospitals disclose their specific reasons for rendering an adverse credentialing decision – whether it's economically based or not – and that an opportunity for a fair hearing be provided. ISMS legal counsel believes that current standards of the Joint Commission on Accreditation of Healthcare Organizations already call for a fair hearing and appeal process.

"This legislation would provide an opportunity for physicians to find out exactly why their application for recredentialing was denied and to respond formally to the hospital's decision," Dr. Traugott said. "The provisions included in this bill are nothing dramatic. They are an attempt to codify, clarify and expand minimum due process procedures for physicians facing adverse decisions."

Dr. Traugott said ISMS acted in physicians' best interests by refusing to accept an IHA provision allowing hospitals to become exempt from the legislation if an institution's governing board and medical staff agree to "opt out" of the due process requirements. "This exception would essentially eliminate the objective of the legislation – setting a statewide policy so that physicians feel comfortable knowing they have the same due process rights at each of the hospitals where they have staff privileges," he said.

S.B. 614 also calls for any economic-based credentialing decisions that limit or revoke a physician's clinical privileges to be reported to the Illinois Health Facilities Planning Board. The board would then use this information to study economic credentialing and report on the extent of the problem to the governor and the General Assembly by Jan. 1, 1996. During negotiations, ISMS did not accept IHA's request to remove this reporting mechanism from the bill because of the importance of independently evaluating how hospitals' economic credentialing affects patient care in Illinois.

Although the hospital association and ISMS failed to reach an agreement about S.B. 614, the issue is not dead, Dr. Traugott said. When legislators return to Springfield June 23 to conclude the session's business, including acting on the state budget, credentialing could be among the issues they address. ■

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(Continued from page 1)

subscribers will be reimbursed, and nonparticipating physicians will have to collect from these patients. Participating physicians will continue to receive direct reimbursement for claims they submit.

The second change relates to the fee schedule BCBSI uses for two of its managed care plans – PPO Plus and Managed Care Network Preferred. Changes to the Schedule of Maximum Allowances are a "first step to have the SMA migrate more toward the [Medicare] Resource-Based Relative Value Scale (RBRVS) physician payment methodology," the physician letters said. BCBSI has reviewed its maximum allowance for each CPT code, and most reimbursement for CPT codes related to primary care and office visits – the E and M codes – will remain the same. Some maximum allowances will increase such as the one for vaginal deliveries. Others, including several related to surgical and orthopedic specialty procedures, will decrease by as much as 15 percent. According to Blue Cross Medical Director Arnold L. Widen, MD, about two-thirds of the carrier's PPO-participating physicians could be affected by the fee cuts. But because many of these doctors already charge below Blue Cross' maximum fees, only about half will see a decrease in reimbursement, he said.

> *The charge of the TPPP Committee is to work with Blue Cross [officials] to help them recognize the importance of quality issues and the importance of working with physicians to attain quality care.*

In addition, payment will be reduced for more than one surgical procedure performed during a single treatment episode. Although physicians will continue to receive 100-percent reimbursement for the first surgical procedure performed, they will receive 50-percent reimbursement for other procedures performed at the same time. For example, if a physician first removes a patient's gall bladder and then the appendix during the same operation, the doctor will be paid 100 percent for the first procedure and 50 percent for the second, not 100 percent for each.

BCBSI is also instituting other changes to increase its cost-effectiveness. A contracted specialist network is being developed for implementation next year. The network will comprise physician specialists on staff at BCBSI PPO hospitals who have signed contracts indicating they "accept managed care concepts and that they will comply with patient care protocols pertaining to their areas of specialty," according to a letter sent to MCNP primary care physicians. BCBSI is also creating an MCNP incentive program aimed at decreasing inpatient hospital utilization and referrals for specialty services. To save laboratory costs, BCBSI is contracting with independent clinical labs that agree to "accept a negotiated appropriate fee as payment in full," the letter continued.

The ISMS Third Party Payment Processes Committee is currently studying these initiatives and will work with BCBSI officials to ensure quality care remains a priority. "[The changes to] Blue Cross' managed care plans do deal with cost issues such as decreasing length of stay and decreasing costs for certain lab services by contracting with a select number of labs, but they need to move beyond just talking about cost issues and consider quality and outcomes," said John F. Schneider, MD, TPPP Committee chairman and an ISMS Third District trustee.

Dr. Schneider said that although BCBSI does have to address cost controls to remain competitive and attract clients, the carrier must also prove that its systems and participating physicians are still delivering high-quality patient care. One way to accomplish this, he said, is delegating the responsibility for developing practice guidelines and protocols to the physicians who actually participate in the plans and deliver the care.

"The charge of the TPPP Committee is to work with Blue Cross [officials] to help them recognize the importance of quality issues and the importance of working with physicians to attain quality care," Dr. Schneider said. "A major challenge for both TPPP and Blue Cross is as you attempt to deal with limiting cost through managed care, you need to involve physicians. It can't be accomplished by having an outside group dictate how physicians practice. I'm much more amenable, as a physician, to sitting down and discussing how to shorten the length of stay for C-sections, than being told, 'You just have to do it.'"

For more information about these changes or about becoming participating providers, physicians may contact BCBSI at (800) 538-7560. ■

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IANCES ROLE OF EXCHANGE REPS (PAGE 9)

1993 LEGISLATIVE HIGHLIGHTS

PAGE 2

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JULY 16 1993



P. John Seward, MD, re-elected AMA trustee

PAGE 13

Vest ruling stands

RULE 224: The Illinois Supreme Court's refusal to hear a plaintiff's appeal supports discovery limits. By Anna Brown

[BELLEVILLE] In the case of *Roth vs. Vest*, the Illinois Supreme Court denied the plaintiff the right to appeal an appellate court decision that a rule regarding discovery limits had been used inappropriately. The court did not specify why it refused to hear the case.

The June 3 decision reinforces current state law stipulating that plaintiffs must seek a certificate of merit from a third-party physician before filing malpractice suits. The affidavit requirement helps eliminate frivolous lawsuits from the already backlogged court system. Under the decision, physicians will also be protected from discovery when their attorneys are not present.

"We won," said James V. Vest, MD, a Belleville pulmonary disease specialist. "Everything worked out. Rule 224 can't be used for fishing

(Continued on page 19)

INSIDE

Task force releases women's health agenda

PAGE 4



Sister Sheila Lyne held in contempt of court

PAGE 5

DEPARTMENTS

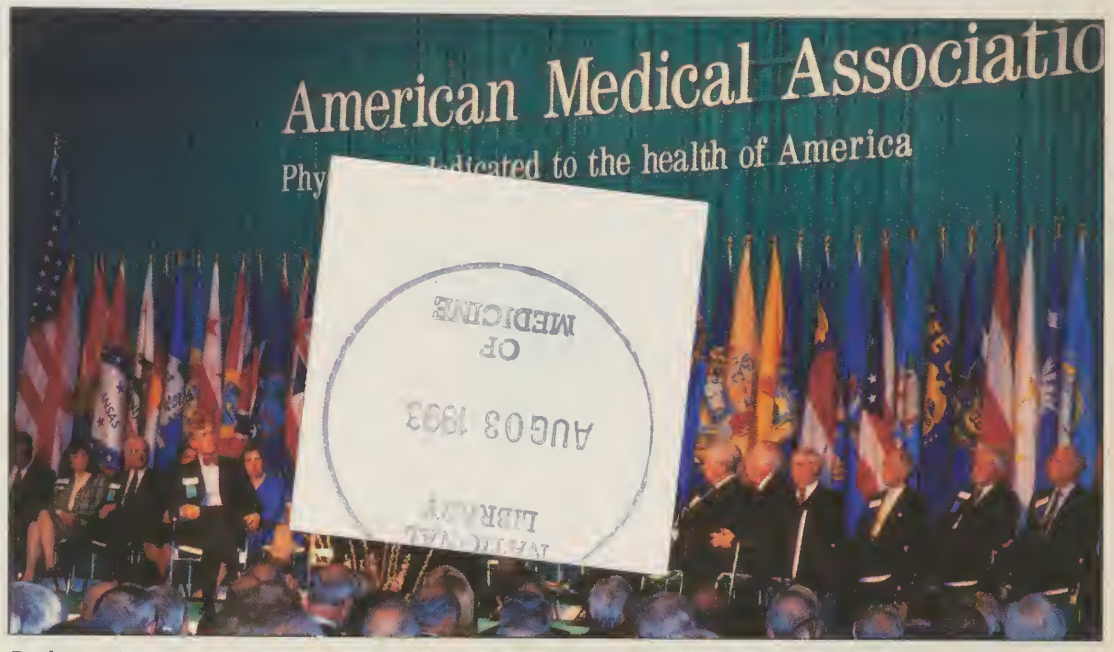
News Briefs.....3

Commentary.....6

ISMIE Update.....9

Exchange Board Briefs.....11

Classifieds.....15



During a June 13 address to the AMA, Hillary Rodham Clinton promised physicians tort reform in exchange for improved self-policing of medicine. Illinois physicians, however, are withholding judgment on her offer until they can review the details. (See story, page 12.)

Senate passes credentialing study

DUE PROCESS: Illinois lawmakers endorse a statewide study on economic credentialing. By Anna Brown

[SPRINGFIELD] Illinois physicians scored a legislative victory July 2 when the Senate voted 55-0 to adopt a resolution calling for a study of economic credentialing practices. Senate Resolution 667, sponsored by Sen. Patrick J. O'Malley (R-Palos Park), directs the Illinois Health Facilities Planning Board to examine economic-based clinical privilege decisions. Specifically, the study will look at how those decisions affect access, quality of care and the availability of physician services. The board must report its findings to the governor and the General Assembly by Jan. 1, 1994.

"We applaud the Senate's action in passing this resolution," said ISMS President Arthur R. Traugott, MD. "We succeeded in raising lawmakers' consciousness about the complex issue of economic credentialing and kept the legislature focused on the problem. In the face of stiff opposition from the hospital community, we did not back down and accept a watered-down compromise that would have done nothing to protect the due process rights of

(Continued on page 18)

SETTING THE RECORD STRAIGHT

It's time to set the record straight about why ISMS entered the fight against H.B. 1300, the bill requiring parental notification of a minor's abortion. ISMS opposed the bill IN ITS FINAL FORM because proponents insisted on including civil punishment for physicians, in addition to existing regulatory penalties.

Appropriate penalties are now in place to discipline doctors who willfully fail to comply with state law. Illinois' medical disciplinary system allows for the imposition of fines as well as license limitations, suspensions or revocations. In addition to facing state disciplinary action, physicians also can be sued for malpractice, exposing them to potentially significant damage awards.

ISMS offered to withdraw its opposition to this bill if the penalties for physicians who didn't notify parents had stayed within the medical disciplinary process. H.B. 1300 could have passed if supporters had agreed to drop the excessive and onerous layer of civil penalties the bill placed on physicians. In fact, even after the bill's defeat, ISMS offered to work with proponents to draft language that would be consistent with the disciplinary process for physicians who violate state laws. Proponents again refused.

ISMS did not oppose the parental notification requirement in H.B. 1300. Our opposition had nothing to do with abortion; it had everything to do with fairness to physicians.

Patient alleges HIV testing without knowledge, consent

LAWSUIT: The Illinois ACLU files suit on behalf of a patient tested for HIV. By Anna Brown

[CHICAGO] In one of the first such cases in Illinois, a patient filed suit June 10 alleging that his physician performed an HIV test without his knowledge or permission. Using the pseudonym John Doe, the 43-year-old plaintiff filed suit against William L. Nold, MD, a Skokie internist, in federal court with the support of the American Civil Liberties Union of Illinois. The suit seeks monetary damages and a court order to keep the defen-

(Continued on page 17)

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1993 ISMS legislative highlights

Lawmakers took up a variety of issues affecting physicians during the spring legislative session. ISMS considered the following bills to be legislative priorities this year:

	Bill	Outcome	ISMS Position
Study on economic credentialing by Illinois Health Facilities Planning Board	S.R. 667	Passed	Support
Prevention of stays of disciplinary action absent good cause	S.B. 601, H.B. 1971	Passed	Support
Penalties for the sale of tobacco to minors	H.B. 1576	Passed	Support
IDPR required to obtain complete information before acting on controlled substance licenses	S.B. 602	Passed	Support
License application fee reduction in last year of renewal cycle	S.B. 603	Passed	Support
Mandatory car restraints for children	S.B. 180	Passed	Support
Grants for practicing OB in underserved areas	S.B. 607	Passed	Support
Statute of limitations for minors' injury-related medical expenses	H.B. 433	Passed	Support
Ban on court-ordered birth control use	H.B. 671	Passed	Support
Government-run health care system	S.B. 303, H.B. 1459	Failed	Oppose
Therapeutic drug treatments by optometrists	S.B. 333	Failed	Oppose
Expanded autonomy for chiropractors	H.B. 219	Failed	Oppose
Direct reimbursement of nurse practitioners	H.B. 2048	Failed	Oppose
Mandatory Medicare assignment	S.B. 655, 656; H.B. 1504, 1505	Failed	Oppose
Prejudgment interest	H.B. 2111	Failed	Oppose
Plantiffs allowed to file lawsuits against a fictitious person, nullification of certificates of merit	S.B. 18, H.B. 1369	Failed	Oppose
Public access to now-private lawsuit documents	H.B. 1930	Failed	Oppose
Freestanding birthing centers	S.B. 228, H.B. 552	Failed	Oppose
Unrealistic time frame for self-referral compliance	S.B. 977, H.B. 1928	Failed	Oppose
Licensure fees tripled, denial of physicians' due process	S.B. 978; H.B. 1503, 793	Failed	Oppose
Expansion of medical staff members' minimum due process rights in economic credentialing	S.B. 398, 614	Tabled	Support
Caps on noneconomic damages	S.B. 344, H.B. 1432	Tabled*	Support
Mandatory motorcycle helmets	S.B. 69	Tabled	Support
Tattoo parlor licensing requirements	H.B. 1973	On interim study	Support
Smoking ban in stadiums	H.B. 1988	On interim study	Support
Ban on 90-day extensions for plaintiffs to file certificates of merit	S.B. 372	On interim study	Support

** Passed in Senate, tabled in House*

Register for ISMS, IHA, CMS reform program

[CHICAGO] There's still time to register for the July 22 ISMS, Illinois Hospital Association and Chicago Medical Society program, "Physician/Hospital Collaboration in an Era of Health Care Reform." The three organizations are sponsoring the program to discuss the relationship of hospitals and medical staffs in managed care environments. All physicians and hospital administrators are encouraged to attend.

The program will feature overviews of hospital-physician relationships and existing models of these relationships in managed care. The agenda also includes a discussion of the probable impact of the Clinton administration's impending reform plan and its potential effect on collaboration between doctors and hospitals. Program speakers include Jeff Goldsmith, national adviser to Ernst and Young and president of Health Futures Inc.; William G. Plested, MD, past president of the California Medical Society; and Lee McCormick, MD, chairman of the AMA Hospital Medical Staff Section Governing Council.

The seminar will be of special interest to medical staff chiefs, hospital medical staff section representatives, and hospital CEOs and board chairmen. The day-long program qualifies for seven hours of CME credit in Category 1 of the AMA Physician's Recognition Award. It will be held at the Drake Oakbrook Hotel from 8:15 a.m. to 5 p.m., with a reception following the program. The $150 registration fee includes lunch and the reception.

To register, call the IHA education department at (708) 505-7777, ext. 572. For more information, call the ISMS health care finance division at (312) 782-1654 or (800) 782-ISMS. ■

ISMS criticizes new survey

[CHICAGO] A new survey conducted by the Coalition for Consumer Rights fails to address key factors driving health care costs in Illinois, said ISMS President Arthur R. Traugott, MD. He noted that the study – which claims widespread dissatisfaction with Illinois' health care system – yields little new information. The poll of 616 registered voters was released June 21 by Illinois Public Action, a self-proclaimed public advocacy group.

In its press release, IPA slants the results to support a national single-payer health insurance system modeled after Medicare, Dr. Traugott said. But this conclusion is not supported by the survey results, he explained.

Although ISMS agrees with IPA that freedom of choice in selecting a physician is essential to the success of health care reform, the Society does not believe a government-run, single-payer system is the answer, Dr. Traugott said.

"IPA's own survey demonstrates that five out of six respondents were at least somewhat or very satisfied with their own health care services," added Dr. Traugott. "ISMS recognizes the need for health system reform. We remain strong believers in building on the current public-private partnership by ensuring that all Illinoisans have access to high-quality affordable health care." ■

PBT offers new HIV disability coverage

[CHICAGO] Physicians' Benefits Trust, sponsored by ISMS and the Chicago Medical Society, is now offering HIV disability insurance. PBT's HIV disability protection is available to all ISMS members. Policies are developed according to physicians' needs, with flexible coverage from $100,000 to $750,000. Confidentiality is assured, and certain plans require no testing.

Physicians insured by an eligible PBT health care plan automatically receive $100,000 in HIV benefit coverage free and may purchase an additional $100,000 of coverage, with no testing required. All interested physicians have the option of purchasing up to $550,000 of additional HIV disability coverage. HIV testing is required for this level of coverage. Physicians not currently covered by a PBT plan may sign up during the 60-day open enrollment period from July 1 to Sept. 1.

PBT marks its fifth anniversary this summer. More than 3,500 physicians are enrolled in its insurance plans. For more information, physicians may call PBT at (312) 541-2704 or (800) 621-0748. ■

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REPORT FOR *Illinois Physicians*

PPO LABORATORY NETWORK

Blue Cross and Blue Shield of Illinois (BCBSI) is pleased to announce another action that has been undertaken by BCBSI to help reduce the cost of health care services while still assuring that the highest standards of quality will be met. BCBSI has been negotiating with large independent clinical laboratories to provide laboratory tests to BCBSI enrollees in its managed care products **in the Chicago Metropolitan Area**. The laboratories were required to demonstrate that they fulfill stringent quality standards, and that they would accept a cost effective payment schedule. The negotiations have been successful and the following laboratories now comprise the network: **Damon, Metpath, National Health Laboratories, and SmithKline Beecham.**

These laboratories are now considered to be PPO providers. As such, MCNP network physicians must refer MCNP patients to these laboratories for all tests other than those that physicians actually perform in their own offices. Billing to BCBSI for all laboratory services may come from the physician's office or directly from the laboratory. The network laboratories have also agreed that the negotiated fee will be the maximum fee that they will charge whether they bill the physician or BCBSI directly. However, if, as may be possible, you already have or wish to directly negotiate a better fee than BCBSI has received from these PPO laboratories, the laboratory, of course, will bill you at those lower rates.

In addition to the independent laboratories listed above, the clinical laboratories of all PPO hospitals are considered to be PPO laboratory providers and therefore physicians may also refer their patients to those institutions for laboratory tests. However, BCBSI has not concluded fee negotiations with the PPO hospital laboratories; consequently the hospital's laboratory charge may be higher than that agreed to by the above independent laboratories. Once again, physicians can also perform any laboratory tests in their own offices.

Concurrent with the establishment of this laboratory network, BCBSI has reduced the maximum fee, allowed under the MCNP and PPO+ Schedule of Maximum Allowances (SMA), for laboratory tests, with certain exceptions noted below. However, the new maximum fees do permit physicians to realize a substantial mark-up from the fees that they will be charged by the independent clinical laboratories. This mark-up represents appropriate compensation to physicians for their interpretation of the tests, the incorporation of the results in their diagnostic and treatment decisions, and their communications with their patients about the tests.

Certain common, simple laboratory procedures will be exempted from the new maximum fee indicated by the Schedule of Maximum Allowances (SMA). These tests will be paid for at fee levels that have been in effect before the new SMA laboratory allowances were instituted. The **"exempted"** laboratory tests are as follows: **Complete Blood Count**, with or without differential, or any subset of a complete blood count (e.g., Hemoglobin or Hematocrit alone, WBC alone, etc.); **Platelet Count; Urinalysis; Pregnancy Test; Occult Blood in Feces; Blood Glucose; Erythrocyte Sedimentation Rate; Throat Culture; Wet Mount of Vaginal Secretions; Tissue Examination for Fungi** (e.g. KOH Slide); **Obstetric Panel; Pap Smear.**

The new PPO laboratory network, and the new laboratory Schedule of Maximum Allowances, will go into effect on July 1, 1993. ***If you have any questions about these new initiatives, please call 312-938-7433.***

(Issue: 07/16/93 - ALW)

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Task force releases women's health agenda

URBAN HEALTH: Chicago unveils a blueprint for pilot health care programs. By Gina Kimmey

[CHICAGO] The 40-member task force on women's health convened by Chicago's Mayor Richard M. Daley released its initial report last month on improving health care delivery to women in urban areas. At a June 14 press conference, Daley said the Urban Women's Health Agenda identifies barriers to better health care and offers guidelines for developing model programs to benefit women and girls in cities across the country.

"There are growing medical and social differences between men and women, and a clear indication of a need for change in our health care industry," Daley said. "This agenda will play a helpful role in the national dialogue for improving women's health."

The task force began its deliberations in April under the direction of co-chairmen Sister Sheila Lyne, RSM, Chicago health commissioner, and Hedy Ratner, co-director of the Women's Business Development Center. Three ISMS members – all Chicago-area Ob/Gyns – are also members of the task force. They are Allan G. Charles, MD; Linda H. Holt, MD; and Julian B. Ullman, MD. Releasing the agenda marks the completion of the group's initial goal.

"Most of us can recite the list of diseases that are devastating to women in particular," said Sister Sheila, adding that the agenda is the first step toward breaking down access barriers and solving the challenges in women's health care. "It has been most encouraging to see the mayor's task force go beyond what other groups have done, and actually propose solutions to the barriers that women and girls face every day in our nation's cities."

According to the Chicago Department of Health, the task force will use the Urban Women's Health Agenda in the next few months as a springboard to plan and implement pilot health care programs targeted at women and girls in Chicago.

"This collective sharing of expertise – across disciplines and among people whose day-to-day contacts with the health care system vary dramatically – will, in the end, enable us to service women best," Ratner said. ■

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ISMS provides HIV testing guidelines

[CHICAGO] In light of a recent lawsuit, information regarding HIV testing is especially relevant. The ISMS Medical Legal Council offers guidelines for physicians to properly conduct HIV testing for their patients. According to the council, physicians have "virtual autonomy" when deciding to test a patient for HIV. This concept can be used as a guide in obtaining permission to perform HIV tests.

According to the Illinois AIDS Confidentiality Act, physicians need not obtain written informed consent for HIV testing in the following circumstances:

• When a health care provider or health facility uses a human body part donated under the Uniform Anatomical Gift Act or if semen is provided for artificial insemination.

• When testing a health care provider, health facility employee, firefighter or emergency medical technician involved in accidental direct skin or mucous membrane contact with the blood or bodily fluids of an individual who in a physician's judgment may be HIV positive. If the test is positive, the patient and the health care professional must be provided appropriate counseling consistent with the Act.

• When a law enforcement officer is involved in mucous membrane contact with the blood or bodily fluids of an individual who in a physician's medical judgment may be HIV positive.

• When the testing is conducted for research, provided the subject's identity is not known and may not be retrieved by the researcher. The test subject also may not be informed of the results.

• When, in a physician's best judgment, testing is medically indicated in order to provide appropriate diagnosis and treatment to a patient who has already consented to medical treatment from that physician. ■

Health commissioner defies judge's ruling

LEAD TESTING: Sister Sheila Lyne is held in contempt of court following a disagreement about spending lead testing funds. By Anna Brown



Sister Sheila Lyne was detained by sheriff's deputies following a lead-testing dispute.

[CHICAGO] Chicago Health Commissioner Sister Sheila Lyne, RSM, was detained by sheriff's deputies for two hours June 16 for failing to comply with a judge's order to test middle-school students for lead poisoning.

When lead-based paint was discovered on the walls of some West Side schools, Judge Morton Zwick ordered all students at the Lawndale Community Academy to undergo lead testing. Sister Sheila defied Zwick's order to test the Lawndale students, maintaining it would divert funds from other schools where testing had already been targeted for younger children. Testing children over age 6 is unnecessary, because older children are at lower risk for lead poisoning, said Tim Hadac, Chicago Department of Health spokesperson.

"We're concerned this would set a dangerous precedent," Hadac said. The department has already slated students at 64 Chicago public schools for testing, he said, adding that this case "could open the floodgates" for citywide testing of all schoolchildren. "It's bad public health policy, and CDOH is fighting it tooth and nail."

According to Hadac, Zwick ignored affidavits filed in support of the department's position by the Illinois Department of Public Health, the Cook County Department of Public Health and the U.S. Centers for Disease Control and Prevention. Current Illinois law mandates that all children under 6 years receive at least one lead-level blood test before they enter school or day care. ISMS has endorsed legislation establishing effective lead abatement programs as part of its ongoing support for legislation to identify and treat lead poisoning in children.

SISTER SHEILA WAS HELD by Cook County sheriff's deputies in a conference room near the health department's offices in the Daley Center until Illinois Supreme Court Justice Michael Bilandic stayed the contempt ruling and Zwick's order to test the children. The city appealed Zwick's decision to the appellate court and the Supreme Court, said Andrea Brands, city law department spokesperson.

On June 22, the Supreme Court denied and dismissed the city's motions until all legal means, including the appeal, have been exhausted, Brands said. The city asked for an expedited briefing schedule, hoping the court will reach a decision before school starts this fall, she said. Zwick agreed to continue the case, pending the appellate court decision.

"The school did not have a lead problem," Brands said. School officials had corrected a prior violation, but no children were at risk for lead exposure according to CDC guidelines, she added.

Terry F. Hatch, MD, president of the Illinois Chapter of the American Academy of Pediatrics, said children over 6 can be affected by lead, but explained that high lead levels more directly affect the "psycho-emotional element" in younger children.

"Lead should be considered with learning disabilities, regardless of age," said Thomas J. Herr, MD, a Moline pediatrician. Testing children in middle school could be reasonable, but it is not necessary, Dr. Herr said.

"The current law does us a service by forcing recognition of this issue," Dr. Hatch said. He added that although children are currently being tested throughout Illinois, he is concerned that the General Assembly has not allocated funds for treatment or abatement programs. "Lead abatement can be simple but very expensive," he said.

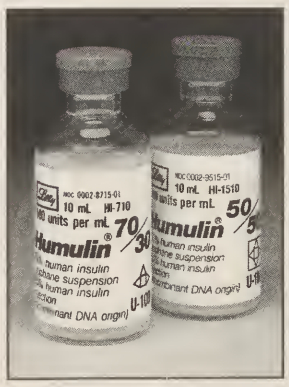
"People just don't have the resources," Dr. Herr noted. He and Dr. Hatch agreed that physicians can help patients lower their risk for lead poisoning and other illnesses by stressing good home maintenance. ■



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Illinois Medicine

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EDITORIAL

Your winning newspaper – thanks to you!

Thanks to the *Illinois Medicine* Committee and all those ISMS members who participated in a 1991 readership survey, *Illinois Medicine* won two Excel Awards from the Society of National Association Publications. In June, SNAP announced that our publication had won a second-place award for most improved newspaper, based on its 1992 redesign, and a third-place award for best newspaper feature article. The winning story was "Living on the Other Side of the Stethoscope," an interview with a physician who contracted AIDS.

Illinois Medicine was redesigned to implement feedback from the readership survey, with the teamwork of the *Illinois Medicine* Committee and staff. Survey results shaped significant changes in format and content. Because the survey showed that readers prefer concise, capsulized news stories, the format was changed to allow for more short stories.

The survey also showed that two-thirds of the readers rely on the newspaper to stay up-to-date on legislation affecting medicine in Illinois. So, legislative coverage was expanded. More space was devoted to tort reform, because more than half of the readers surveyed said they are very interested in it.

"News Briefs" was ranked one of the newspaper's most popular departments, resulting in more briefs per issue. Three-fourths of survey respondents said they are interested in reading about medical professional liability, so "ISMIE Update" was created to provide this information in every issue.

Those elements that were working remained the same. Nearly 75 percent of those surveyed said the newspaper "presents the right balance of professional and association news." Readers were also happy with the newspaper's tabloid format.

The survey also told us about you – the reader – and your reading habits. More than half of survey respondents read 50 percent or more of each issue.

With all the demands they face, physicians don't have much free time for other activities. Yet many doctors took the time to complete a four-page questionnaire, and their responses formed the basis for the redesign. In addition, the physician members of the *Illinois Medicine* Committee meet regularly to discuss story ideas and fine-tune every aspect of the newspaper. The names of these dedicated contributors are listed in the masthead box on this page.

And, finally, every ISMS member who reads the newspaper, writes or calls with a suggestion, or agrees to be interviewed for a story contributes to the publication's success. A publication is successful only to the degree that it meets the needs of its readers and reflects their input. Your direction brought recognition to ISMS.

Keep it up, and thanks!

PRESIDENT'S LETTER

Fostering good 'customer relations'

By Arthur R. Traugott, MD



Unaddressed slights, miscommunications and grievances can come back to haunt us.

While attending the AMA annual meeting, some friends and I decided to take the evening off to watch the Bulls in Game No. 4 of the NBA playoffs. We chose a yuppie sports bar where the customers seemed to be enjoying the game. Our waitress came by with menus, and we were surprised by the upscale offerings. When the waitress returned to take our orders, one of my friends said he wanted a plain old hot dog. The waitress nicely informed him that the restaurant didn't serve hot dogs. My friend, however, kept insisting. But the waitress stood her ground equally firmly. Finally, my friend asked what he could do to get a hot dog. The waitress pulled out a card and handed it to him. "What's that?" he asked. "It's a comment card," she said, "and you can let the management know you'd like hot dogs on the menu." We all broke into laughter, realizing she had nicely and politely brought closure to the dispute.

Through that experience, we all learned a lesson about how we could improve our relations with patients. Too often, we brush off their requests as being impossible to implement or unrealistic. We don't try to accommodate them. Then, when patients have a complaint and we don't provide them with a way to vent, they become more frustrated and angry with us.

Some of the media have recently claimed that there should be more physician discipline. As a result of my subsequent discussions with the media about the basis for their claim, I believe that key factors are personal dissatisfaction with individual physicians and patients' lack of a way to express that discontent. The public is interested in addressing grievances about physicians and, if complaints go unresolved, having them sent through official disciplinary channels. Patients want something to be done about their complaints.

Underlying many complaints is the fact that patients want to be treated with dignity and respect. Something as simple as waiting too long in our reception area may cause them to be discontented with us as physicians. Then, they may become even more upset if we don't take the time to fully explain diagnoses and treatment to them. Brusque treatment infuriates them. After they're already upset, a curt response on the phone certainly doesn't smooth ruffled feathers. After all, who among us has never experienced a billing problem and wanted an immediate resolution?

These unaddressed slights, miscommunications and grievances can come back to haunt us. Insurance studies tell us that a dissatisfied customer is three times more likely to tell others about treatment received than is a satisfied customer.

What's worse is that dissatisfied patients equate bad customer relations with bad doctors. When they have no way to address the problem, they expect the disciplinary board to correct the situation. This confuses the issue because the disciplinary board should be reserved for addressing problems of professional competency and ethics that cannot be resolved through basic complaint resolution.

In my practice, we instituted a hot line through which patients could phone in their complaints. After the hot line had been in effect for about a year, I noticed a change in our behavior. We began actively trying to avoid creating problems for our patients, and when complaints did occur, we worked at resolving them. When we started treating our patients differently, the number of complaints dropped.

If we all tried to deal with our patients' concerns and complaints more immediately and directly, we might begin to change the public's perception about disciplining physicians. Maybe we should start by following the waitress's example and handing out comment cards.



DON'T FORGET TO RENEW YOUR LICENSE

All physicians licensed to practice medicine in Illinois must renew their medical licenses by July 31. Failure to do so could subject physicians to disciplinary action by the Illinois Medical Disciplinary Board and loss of their Exchange liability coverage for the time they practice without a valid license. By now, physicians should have received a packet from the Illinois Department of Professional Regulation containing the necessary forms to complete the renewal process. Physicians who have not yet received the forms should contact the department at (217) 782-0458. ■

GUEST EDITORIAL

How I reversed an unfair UR denial

By Robert S. Hoffman, MD

Last summer, an elderly patient asked me to write his insurer a letter on his behalf. The carrier, it seemed, wouldn't reimburse him for a prescription I had written. I got my patient his money, but only after 8½ hours of letter writing and research in the local medical library – a time-consuming yet satisfying victory. Here's how, with persistence and a bit of an acid tongue, I got it done. (I've changed the names so as not to further embarrass the guilty.)

Aug. 19, 1992

Dear Mr. Smith:
As you requested, I am writing to confirm that I am prescribing nortriptyline for you. This is not being given for any psychiatric problem, but rather to lessen the pain and paresthesias in your legs. I hope this suffices to get the drug paid for by your insurance company.

Sincerely,
Robert S. Hoffman, MD

Sept. 1, 1992

Dear Dr. Hoffman:
In your letter to Mr. Smith dated Aug. 19, 1992, you mentioned that nortriptyline was used not for any psychiatric problem but rather for its effect on pain, to treat the painful paresthesias in his legs.

One of the adverse reactions of this drug is numbness and paresthesias of extremities. Based on this, we regretfully cannot accept your reason for the use of nortriptyline on Mr. Smith.

Please do not hesitate to contact us if we can be of any further assistance.

Very truly yours,
Constance Strife, MD
Blue Sky Insurance Co.

Sept. 8, 1992

Dear Dr. Strife:
I am in receipt of your letter dated Sept. 1, 1992, regarding the issue of whether you plan to reimburse Mr. Smith for the prescription I gave him for nortriptyline. You state, "One of the adverse reactions of this drug is numbness and paresthesias of extremities." On this basis, you said you could not accept my use of this drug on Mr. Smith.

To put it as diplomatically as I can, I feel that this statement is nonsense and reflects complete ignorance of this subject on your part. Obviously, you looked the drug up in the *Physicians' Desk Reference* and found that the side effects it listed included "numbness, tingling, paresthesias of extremities." However, anyone who has used this drug, as I have over the past 20 years, knows that these side effects never occur.

In fact, nortriptyline and its parent compound, amitriptyline, represent first-line drugs for chronic-pain conditions, including those related to peripheral polyneuropathies. Although most of the studies on pain patients were done with amitriptyline, rather than nortriptyline, most modern neurologists employ nortriptyline because it has a much better side-effect profile than the parent compound.

The most generous interpretation I can put on your decision is that you are in fact quite aware that what you are saying is nonsense and that you are simply making up a reason not to pay for the drug in order to save your employer money. If this is the case, obviously any argument I can make to you will have no impact. Therefore, I am also sending a copy of this letter to the patient, with strong encouragement that he spare no expense and effort in complaining about this to your company.

In conclusion, I think that your behavior in this matter is utterly reprehensible.

With best regards, I remain
Cordially,
Robert S. Hoffman, MD

Sept. 15, 1992

Dear Dr. Hoffman:
You mentioned in your letter dated Sept. 8, 1992, that nortriptyline and its parent compound, amitriptyline, represent first-line drugs for treatment of any chronic pain condition, and that nortriptyline is standard treatment among all neurologists, as well as other physicians who deal with chronic-pain patients.

In order to substantiate your use of nortriptyline, kindly send to this office any medical literature showing nortriptyline or amitriptyline as the first-line drug for treatment of chronic-pain conditions. Upon receipt of this information, we would be more than happy to re-evaluate this patient's coverage of nortriptyline.

Very truly yours,
Constance Strife, MD
Blue Sky Insurance Co.

Sept. 21, 1992

Dear Dr. Strife:
It was an inexpressible pleasure to receive your letter of Sept. 15, indicating your continued refusal to pay for Mr. Smith's prescription and requesting references to support my use of nortriptyline in chronic-pain conditions. I enjoy nothing more than spending hours in the medical library locating and photocopying reprints to educate utilization review officials who are unfamiliar with standard treatments in neurology. Especially when, by my rough calculation, the time I spent on this matter is worth eight times the value of the prescription in question.

Therefore, I have enclosed 11 references from standard medical textbooks and journals, supporting the use of tricyclic antidepressants in chronic-pain conditions.

I feel that these references will still fail to convince you that I'm practicing neurology properly. If that's the case, simply let me know, and I shall be more than happy to photocopy two or three dozen more reprints for you. Or, if you prefer, I will obtain some signed affidavits from other prominent neurologists, including perhaps some professors, specifying that I'm a good doctor and know what I'm doing.

Whatever you desire, I stand ready and eager to comply. I should emphasize that I have endless free time available to respond to your requests. The only problem, of course, is that I am so busy dealing with utilization reviewers these days that I have little time left to see patients. But I consider this a very minor annoyance now that I understand the true purpose of being a physician, which is to document and justify medical care rather than to provide it.

In gratitude for your continued close attention to this matter, I remain

Affectionately,
Robert S. Hoffman, MD

Sept. 24, 1992

Dear Dr. Hoffman:
We are sorry for all the inconvenience our request for further information may have caused you. This request was made in an effort to ensure that all claims are paid properly in accordance with the rules and regulations of Blue Sky Insurance Co. We are pleased to advise you that after reviewing all the documentation you submitted, medical necessity is noted for the use of nortriptyline for Mr. Smith's painful paresthesias. As such, all the charges related to his purchase of this prescription will be covered in accordance with the rules and regulations of Blue Sky Insurance Co. If you should have any further questions, please do not hesitate to contact us.

Very truly yours,
Constance Strife, MD
Blue Sky Insurance Co.

Dr. Hoffman is a neurologist in Daly City, Calif.

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PAGE 10

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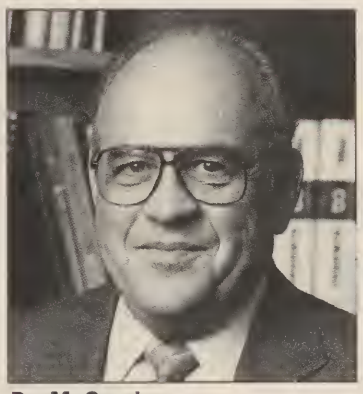
PAGE 11

Action plan enhances role of Exchange reps

The goal of improving service leads to reorganization of the Exchange's network of policyholder representatives. By Gina Kimmey

Inspired by the Physician-First Service initiative, the Exchange's Policyholder Services Committee is dedicated to fostering a more personalized and caring approach toward policyholders. To achieve that aim, the committee is revitalizing the company's 10-year-old physician network. The network comprises volunteer physicians from hospitals and county medical societies who act as liaisons between ISMIE policyholders and the Exchange. The committee's newly announced action plan expands the role of the network representatives to better serve the Exchange's physician owners.

"When the network began, we envisioned it to be an outreach program and to create a loop for information with individual policyholders. We haven't changed that original concept; we have revitalized it," said Boyd E. McCracken Sr., MD, chairman of the Policyholder Services Committee.



Dr. McCracken

"We are responding to the initiative of the Physician-First Service plan. It increases the responsibility of the network representatives and places a renewed emphasis on what we are here to do."

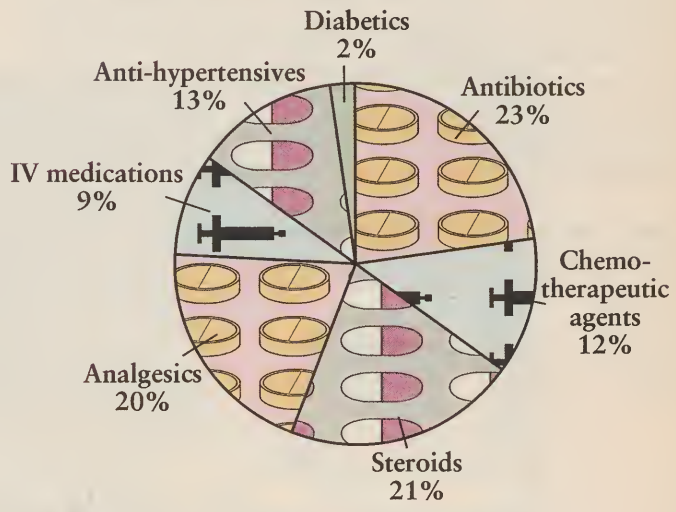
The action plan focuses on re-educating physician network representatives so that they are fully prepared to address policyholder questions and concerns. The representatives will be responsible for educating current policyholders and other physicians about the programs and benefits available to ISMIE insureds. Representatives will receive up-to-date information on professional liability issues and any Exchange policy changes to share with their colleagues. In turn, they will provide policyholder feedback to the Exchange.

"The real benefit of a physician-owned company is that [physician owners'] needs are our needs," added Dr. McCracken. "The physicians in leadership are concerned with responding to the needs of the physician owners."

The network action plan is an "excellent example of what the service initiative is all about," said Harold L. Jensen, MD, chairman of the Exchange Board of Governors. "The Exchange is continually finding new ways to make itself more readily available to its insureds. The representatives are fellow owners who share the same problems and concerns of other

(Continued on page 10)

Drugs most often involved in Exchange drug-related claims



Source: Illinois State Medical Inter-Insurance Exchange

MALPRACTICE ROUNDUP

PIAA studies breast cancer claims

Over the past three years, the Physician Insurers Association of America has conducted studies on the nature and causes of malpractice claims. The studies also examined areas of high incidence and associated malpractice costs. As reported in *Advisor*, the newsletter of the Physicians Protective Trust Fund, one study focused on 273 paid claims arising from delayed breast cancer diagnoses reported by 21 PIAA-member companies.

The results showed that most claims, including those with a large proportion of indemnity payments, were caused by a delay in diagnosis of cancer in women under 50. In 69 percent of all claims, patients themselves found the lesions, indicating that self-discovery may often be ignored, especially in younger women, who are believed to have a lower incidence of malignancy than older women have. Almost half of the claimants had false-negative or equivocal mammogram results, which occur most often in women under 40. The study also reported that in 37 percent of all cases, family history was reported as unknown.

Physicians indicated that delayed diagnosis occurred most commonly because physical findings during the examination failed to raise suspicion, according to the study. The second most common reason was a negative mammogram report, most often occurring in premenopausal patients. The study's findings suggest that once a patient presents with a problem, regardless of age, a physician should treat the complaint seriously and pursue all methods available in making a diagnosis, including taking a complete family history. The study also shows the need for women to perform self-examinations, as well as to receive thorough examinations and regular mammograms. ■

California caps challenged

As reported in *Business Insurance*, California's 1975 Medical Injury Compensation Reform Act is again being challenged by the California Trial Lawyers Association. The Act limits noneconomic damage awards in medical malpractice cases.

A program sponsored by the Northern California Chapter of the Professional Liability Underwriting Society featured a debate between trial lawyers and tort reformers. The program began a statewide debate over the law's future now that the five-year "truce" between the two sides has expired.

The CTLA argues that the law has not reduced medical costs and should be repealed. It claims that since the law was enacted, health care costs have continued to soar in California, making it the second most expensive health care market in the nation. But supporters of the law disagree. Barry Keene, a former state legislator and author of the Act, said that because of the law, malpractice premiums for California's high-risk specialists are one-half to one-third lower than those charged in other states.

The law capped noneconomic damages at $250,000, established a sliding scale for lawyers' contingency fees and permitted insurers to make periodic payments when future damages are more than $50,000. The Act was passed after malpractice insurance premiums surged 400 percent between 1974 and 1975, and the number of insurers willing to underwrite California doctors plummeted from 30 to three. The AMA's recommendations for national tort reform were constructed using MICRA as a model. ■

Guidelines for organ donation, patients' rights



The Uniform Anatomical Gift Act [755 ILCS 50/1 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 110 1/2, pars. 301 – 353], passed by the Illinois General Assembly in 1969, established legal procedures for donating all or part of a human body after death, to be used for specific purposes. The law allows individuals to make anatomical donations by executing a specified document. Anatomical gifts can also be made on behalf of a deceased person by individuals who have the legal authority to make such decisions.

Specifics regarding the Uniform Anatomical Gift Act are included in the ISMS brochures "A Physician's Guide to Advance Directives," "Organ Donation" and "A Personal Decision." "A Physician's Guide to Advance Directives" provides information in a question-and-answer format and may be used as a reference for physicians. "A Personal Decision" contains patient-oriented materials.

PATIENTS' RIGHTS are established under the Medical Patients Rights Act [410 ILCS 50/0.01 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 111 1/2, pars. 5400 – 5404]. The Act details the following rights:

• Patients have the right to care consistent with sound nursing and medical practices; to be informed of the name of the physician responsible for coordinating their care; to receive information about their condition and proposed treatment; to refuse any treatment, to the extent permitted by law; and to privacy and confidentiality of records, except as otherwise provided by law.

• Patients have the right, regardless of payment source, to examine and receive a reasonable explanation of the total bill for services rendered by a physician or health care provider, including itemized charges for specific services received. Physicians and providers are responsible for providing only a reasonable explanation of those specific services they provided.

• In the event an insurance company or health services corporation cancels or refuses to renew an individual policy or plan, insured patients are entitled to timely notice of the termination. An insurance company that requires insured patients or applicants for new or continued coverage to receive an HIV test or test for any other identified causative agent of AIDS must give the patient or applicant written notice of the requirement. The company may then proceed with the testing only with the written authorization of the applicant or patient, and must keep the test results confidential. Notice of an adverse coverage decision may be given to any appropriately interested party, but the insurer may only disclose the test results to a physician designated by the applicant or patient. Any disclosure must be done in a manner that assures confidentiality.

• Patients are entitled to privacy and confidentiality in health care. Physicians, health care providers, health services corporations and insurance companies may not disclose the nature or details of services provided to patients, except in specific circumstances. Information may be disclosed to the patient; the person making treatment decisions for a patient incapable of making such decisions; those parties involved in providing treatment or processing the payment; those parties responsible for peer review, utilization review and quality assurance; and those parties required to be notified under the Abused and Neglected Child Reporting Act and the Illinois Sexually Transmissible Disease Act, or otherwise authorized or required by law.

This right may be waived in writing by the patient or patient's guardian, but physicians or other health care providers may not agree to provide services only on the condition that the patient or guardian agrees to sign such a waiver. ■

Editor's note: This is part of a series on medical-legal issues written by the ISMS Medical Legal Council. These guidelines do not necessarily represent ISMS policy. They address legal concerns that physicians commonly express to ISMS and are intended to serve as only a guide for physicians, not specific legal advice.

Action plan

(Continued from page 9)

policyholders."

This makes the network unique, Dr. McCracken said. The representatives are not just representing the company; they are colleagues and fellow policyholders.

THE PLAN CALLS for heightened communication within the company to help Exchange board members routinely learn about the concerns and questions of policyholders, Dr. Jensen said. This improved communication is critical to the physician community now that so many insurance-related issues are being considered within the health care reform debate, he noted. "Tort reform seems to be gaining strength as a component of health care reform. But exactly what form those changes will take is still unclear. The ISMIE network representatives can share their insights about unwise proposals such as enterprise liability and offer suggestions for helping advance physician-supported measures like caps on noneconomic damages."

Network representatives will be instructed to contact the Exchange to report concerns they believe warrant immediate attention. "This is not intended to form a new layer of bureaucracy, but to be used as a tool to enhance communication among the physician owners," said Dr. McCracken. "We want to encourage their participation in this program and let them know we care about what concerns them, because it concerns us too."

Physicians facing malpractice suits also will receive benefits from the revitalized network, Dr. Jensen said. These physicians will be encouraged to contact their ISMIE representative for help in understanding the litigation and claims review processes and the emotional ramifications of being sued, he added. The representatives will be able to direct doctors to services offered by the Exchange's Physician Support Group.

The Exchange will help network representatives coordinate brief, informal educational sessions for policyholders at their hospitals or at county medical society meetings. Session content will be tailored to the group's needs, based on concerns from those policyholders. Exchange board members will attend these sessions as ISMIE representatives.

"The primary goal of the service initiative is to improve individualized service to policyholders," said Dr. Jensen. "This action plan will make the Exchange more accessible to policyholders throughout the state. By encouraging each policyholder to get involved and voice his or her concerns, we make the Exchange a better service for all the physician owners."

To identify their network representative, physicians may call the Exchange at (312) 782-1654 or (800) 782-ISMS. ■

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ISMIE BOARD BRIEFS

The Illinois State Medical Inter-Insurance Exchange Board of Governors met June 18 at the ISMS Conference Complex in Chicago. The following are meeting highlights:

Dr. Jackman named new ISMIE board member

Jane L. Jackman, MD, a Springfield family physician and ISMS Fifth District trustee, has been appointed to fill a vacancy on the Exchange Board of Governors. Dr. Jackman's term will expire in 1994. To keep her seat on the board after 1994, she must seek renomination and re-election.

Exchange plans new risk management course

The Exchange will offer a new advanced documentation seminar to ISMIE-insured physicians with recurring record-keeping problems. The program will be developed by the Exchange's Risk Management Committee later this year.

ISMIE committees organized for 1993-94

Harold L. Jensen, MD, ISMIE board chairman, reappointed the following ISMIE committee chairmen: Robert M. Reardon, MD, Bloomington, Investment Committee; Lawrence L. Hirsch, MD, Northbrook, Planning Committee; Boyd E. McCracken Sr., MD, Greenville, Policyholder Services Committee; and Jere E. Freidheim, MD, Chicago, Risk Management Committee. Dr. McCracken will also serve as chairman of this year's Nominating Committee.

Exchange offers liability brochure for family physicians

The Exchange's Family Practice Risk Management Subcommittee has produced its first brochure, "Exploring Liability Issues in Family Practice: Failure to Diagnose." The brochure will be mailed to all Illinois family physicians insured with ISMIE.

ISMIE to study various issues

The Planning Committee was asked to study several issues, including the following:

- Liability related to care provided in free clinics;
- Provision of mechanisms to allow physicians earlier retirement options; and
- Modifications to the nominating and election procedures for ISMIE board members and officers. ■

Medication seminar tapes available

The May ISMIE seminar "Medication Mishaps: Causes and Prevention" attracted 200 attendees in Chicago and more than 70 in Springfield. Audiotapes of the program are available from the Exchange for $33, plus $3.50 for shipping and handling. To order the three-cassette package, mail your payment to First Tape, Inc., 770 N. LaSalle St., Suite 301, Chicago, IL 60610. To order by phone, call (312) 642-7793, or fax your order to (312) 642-9624. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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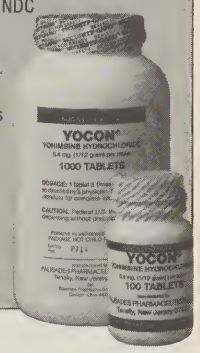
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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AMA ANNUAL MEETING

First lady promises tort reform, fewer hassles

Physicians liked Hillary Rodham Clinton's delivery, but they're reserving judgment about her message.

BY TAMARA STROM

Hillary Rodham Clinton went to the AMA ready to offer America's physicians a bargain. Clinton offered physicians regulatory, antitrust and liability relief in exchange for improved policing of the medical profession. And while she succeeded in delivering a well-received speech to the House of Delegates June 13, Illinois physicians aren't ready to take her up on the offer.

"She told us what we wanted to hear," said James H. Andersen, MD, an Illinois delegate to the AMA and Oak Brook thoracic surgeon. "But she didn't fill in the details. [She] did show she definitely understands all the issues and that obviously she has done exhaustive research. But now the real question is what they will come out with on paper. Until the plan is released, we're talking about smoke and mirrors. There's nothing there."

M. LeRoy Sprang, MD, an AMA delegate and Chicago Ob/Gyn, called the first lady's speech an "excellent presentation." But he said he is concerned that Clinton will spend the summer traveling around the country making equally conciliatory speeches to various constituencies to garner support for the president's plan.

"The devil is in the details," Dr. Sprang said, adding that without specifics it's impossible to endorse a reform plan. "If we provide universal access and ensure quality care while holding down costs, then we will have successful reform. The question is how do we do that? Will it be fairly and equitably achieved, or will it be accomplished on the backs of those participating in the current health care system."



Ted Grudzinski/AMA

HILLARY RODHAM CLINTON

An ISMS Third District trustee, Dr. Sprang is also a member of the Society's ad hoc committee on health care reform. "The more knowledgeable you are on the subject, the more you see that her view of the problem and how to solve it may be too simplistic. She has no experience or expertise in health care. And she's still not getting enough input from the people who know the most about health care – physicians."

During her address, Clinton promised the physician audience a health care system that preserves "what is best in the American health care system today." She said the president stands for universal coverage, community rating and a comprehensive benefits package that emphasizes preventive care. The first lady received a friendly ovation when she said she wants to reduce unnecessary paperwork hassles caused by insurance companies and overblown government regulatory programs like CLIA. She said she also wants to correct the "backward incentives" of insurance company oversight. "There is no master checklist that can be administered by some faceless bureaucrat that can tell you what you need to do on an hourly basis to take care of your patients. And frankly, I wouldn't want to be one of your patients if there were."

The first lady also promised "serious malpractice reform" but offered no details. Although physicians were happy to hear about her commitment to tort reform, her lack of specifics raised red flags. "Although she said we will have a proposal on medical liability reform, she didn't say whether it would be onerous or delightful," said Raymond E. Hoffmann, MD, ISMS first vice president and a Rockford general surgeon. "She pushed all the right buttons and said all the right things, but she ignored many of the important issues."

Dr. Hoffmann said he was impressed by Clinton's speech and her delivery but is skeptical about the outcome of the deliberations of the task force and the president. "Right now they're governing by trial balloon. They have nobody on the committee who really knows organized medicine or the physician base of organized medicine. If they had approached the AMA first, they wouldn't have had to send up the trials. I think it makes them look silly."

Robert M. Reardon, MD, an AMA delegate and Bloomington ophthalmologist, said he was heartened by the tone of her speech, but he, too, is taking a wait-and-see approach. "Perhaps, finally, the government is going to help us instead of hinder us. It sounded as if she understood a lot of our hassles. But we have to keep in mind that just weeks earlier she was bashing doctors in a speech to another audience. Hopefully, if she wants to help our patients as we do, we can work cooperatively. That's what most physicians would prefer."

Dr. Sprang noted that the government must refrain from putting extraneous controls on physicians to preserve the high-quality health care to which most Americans have become accustomed. "Of course, our main concern is quality care for this generation and the next. If we can accomplish universal access and quality care while maintaining free enterprise and freedom of choice, the 21st century will truly be the age of miracles. We have to decide: Do we want an age of miracles or an age of mediocrity?" ■

AMA ANNUAL MEETING

Illinois resolutions succeed at AMA meeting

The AMA House adopted the majority of ISMS resolutions.

BY ANNA BROWN, GINA KIMMEY AND TAMARA STROM

The Illinois delegation made its mark on the AMA House of Delegates when a substitute resolution seeking dissolution of the National Practitioner Data Bank was adopted during the AMA Annual Meeting June 12-17. This was the third year Illinois physicians tried to convince the AMA House to call for the Data Bank's demise. The first two times the Illinois delegation put the issue on the AMA's agenda, delegates voted to allow the AMA Board of Trustees to negotiate corrections for the Data Bank's operational problems. The policy stated that if the House was dissatisfied with government negotiations, the AMA would re-evaluate its policy. Delegates exercised that option this year by adopting new policy to work toward dismantling the Data Bank and affirming AMA support of the Federation of State Medical Boards Action Data Bank.

"That we're pleased with the reference committee would be the understatement of the century," said Illinois Delegate Chester C. Danehower, MD, of Peoria, testifying on the House floor. The reference committee combined three resolutions, including Illinois', calling for the Data Bank's termination and recommending adoption of the substitute resolution.

"How long is too long?" asked Illinois Delegate Dennis M. Brown, MD, of Chicago, testifying in reference committee against the Data Bank. "The National Practitioner Data Bank continues to hurt doctors. Let's bury this thing."

"It's a sad state of affairs when a government puts a body like this in place that impinges on freedom," Dr. Danehower told the reference committee. "We should not tolerate it and do everything we can to terminate it."

In its report to the House, the reference committee indicated that the Federation of State Medical Boards is the "proper medium through which the disciplining and policing of our profession should take place to assure the highest quality of health care and to protect the public." The committee also noted that physician testimony was "strongly supportive of the need for the medical profession to take a leadership role in policing itself."

THE ILLINOIS DELEGATION introduced eight other resolutions for consideration. All were prompted by ISMS House of Delegates action during the Society's 1993 Annual Meeting in April.

The AMA House of Delegates adopted a substitute resolution asking that all third-party payers that use CPT codes distinguish between claims submitted by MDs and DOs and those submitted by all other practitioners. Illinois introduced a similar resolution stating that CPT codes should relate to specific tasks performed by physicians. During the ISMS Annual Meeting, delegates adopted policy calling on the AMA to work to ensure that CPT codes not be used by independent limited-license practitioners who lack the training of physicians and who do not provide the same services.

An Illinois resolution directing the AMA to oppose mandatory electronic submission of Medicare claims was adopted on the consent calendar. The measure also supports physicians' rights to choose whether they transmit paper or electronic claims. Delegates also adopted recommendations that respond to two 1992 Illinois resolutions requesting studies of factors affecting health care costs, particularly nonpatient expenses.

AMA delegates also adopted an Illinois resolution calling on the AMA to oppose attempts by the federal government to freeze physicians' fees. "We need to be extremely active on this issue," said Alternate Delegate John F. Schneider, MD, of Chicago, during floor debate on the issue. He noted that reference committee testimony strongly supported the resolution.

The House also accepted an Illinois resolution regarding improper use of the terms "usual and customary" as a reaffirmation of policy. Existing AMA policy opposes the "inaccurate and/or misleading use of the terms 'usual, customary or reasonable' by insurance carriers in their communications with patients."

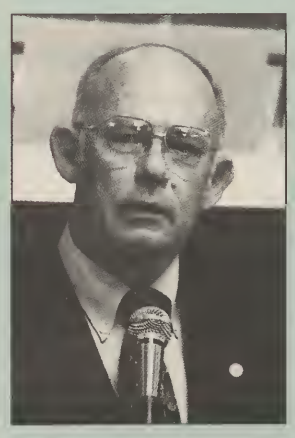
The House referred an Illinois resolution asking the AMA to oppose hospital and medical staff policies allowing no-cause drug testing of physicians during the credentialing process. Several state delegations and the Hospital Medical Staff Section supported the resolution in reference committee.

Delegates also referred an Illinois resolution calling for the AMA to help organizations develop guidelines for infection control at high school athletic events. Illinois physicians submitted the resolution in response to organizations' efforts to develop such guidelines without input from health care professionals. Testimony in reference committee was generally favorable, but many physicians recommended expanding the scope of the resolution to include the North Central Athletic Association, the American Academy of Pediatrics and other interested groups.

The House amended and adopted an Illinois-sponsored resolution directing the AMA to support developing medical school and residency program curricula that include end-of-life care. The amended resolution recognizes ongoing cooperation between the AMA and the Foundation of Thanatology and other organizations to develop such curricula.

Illinois' resolution recommending that the AMA consolidate its policies regarding government medical education loans was adopted by the House with only editorial changes. "The synthesis of policies on loan repayment and the availability of financial aid clarify this important topic," the reference committee said. ■

Illinois fares well in AMA elections



Ted Grudzinski/AMA

DR. SEWARD

Several Illinois physicians and medical students scored victories in the AMA elections held during the June 12-17 annual meeting in Chicago. In the opening days of the meeting, ISMS members campaigned hard to help return P. John Seward, MD, a Rockford family physician, for a second term on the AMA Board of Trustees. Their efforts were successful. Joseph L. Murphy, MD, a Chicago internist, was re-elected for a second term as the alternate delegate from the AMA Hospital Medical Staff Section.

Mark N. Bair, MD, a resident physician from Chicago, was elected vice chairman of the AMA Resident Physician Section. Heidi M. Dunniway, a medical student at the University of Illinois at Urbana-Champaign School of Medicine, was elected vice chair of the AMA Medical Student Section Governing Council. Charles J. Rainey, of Loyola University's Stritch School of Medicine, is the new vice speaker of the AMA Medical Student Section.

Howard B. Chodash, MD, a Chicago resident physician, was unsuccessful in his bid to return for a second term as the resident member of the AMA Council on Medical Education. Dr. Chodash serves as chairman of the ISMS Resident Physicians Section. ■

Smoking issues don't blow away at AMA annual meeting

Tobacco measures lead the AMA's debate on public health issues.

BY GINA KIMMEY

Supporting its goal of a smoke-free society by the year 2000, the AMA House of Delegates debated 10 resolutions aimed at knocking the wind out of tobacco companies. Delegates testified in favor of two resolutions directing the AMA to support legislation reducing or eliminating tobacco companies' tax deduction for advertising and promoting their products.

"The best way to achieve a smoke-free society is to decrease the number of new smokers," said a representative from the Medical Student Section. "Eliminating the tax write-off for advertisers is one way to narrow the gap between the amount of money spent to fight the effects of smoking and the cost of tobacco advertising." According to the AMA, only $114 million is spent yearly to prevent the harmful effects of tobacco use, compared with $3.9 billion spent on advertising.

The reference committee recommended adoption of the resolution, noting the contrast between the cartoon characters as well as the obvious sexual overtones used in advertisements to depict smokers' lifestyles and the "reality of a cancer ward." The resolution also calls for the savings realized from reducing or eliminating this tax deduction to be used for expanding health care services, health promotion and health education. ISMS supported this resolution.

Another ISMS-supported resolution directs the AMA to support restricting tobacco advertising to "generic" ads by banning the use of cartoons, logos, illustrations and other colors. Reference committee testimony underscored current AMA policy endorsing a ban on all tobacco advertising and supported this resolution as a step toward prohibiting such advertising. The House adopted the measure.

Smoking-related resolutions adopted on the consent calendar include measures endorsing smoking bans in prisons; opposing the use of vending machines for tobacco product distribution; establishing smoke-free campuses for business, labor, academia and government; and labeling tobacco an addictive drug.

To help reduce children's exposure to passive smoke, the House adopted a resolution instructing the AMA to urge fast food franchises to prohibit smoking in their restaurants. The resolution supports introduction of legislation to ban smoking in restaurants and other entertainment and food outlets that target their marketing efforts at children.

The best way to achieve a smoke-free society is to decrease the number of new smokers. Eliminating the tax write-off for advertisers is one way to narrow the gap between the amount of money spent to fight the effects of smoking and the cost of tobacco advertising.

GUN CONTROL also received the delegates' attention. ISMS supported the House's action to refer a resolution calling for a ban on all handguns and automatic weapons. Current ISMS policy on gun control attempts to balance public safety and the constitutional right to bear arms.

A resolution, strongly opposed by ISMS, recommending mandatory testing for all "positive HIV contacts" was defeated on the House floor without debate. The House did adopt a resolution endorsing HIV testing for sexual assault victims and encouraging victims to be retested in six months if the initial test is negative. The measure mandates that the test results be kept confidential. ISMS strongly supported this resolution. After extensive debate, the House rejected the reference committee's recommendation for referral; instead it adopted a resolution calling on the AMA to oppose deletion of HIV from the list of diseases that limit immigration and to oppose immigration of those individuals who are HIV positive. ISMS supported this resolution. ■

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HIV testing

(Continued from page 1)

dant from ordering or performing an HIV test on any patient in a nonemergency situation without obtaining informed consent.

"Dr. Nold violated Doe's rights by testing for HIV without obtaining informed consent," said Mathew Nosanchuk, staff counsel for the ACLU AIDS and Civil Liberties Project. Nosanchuk said the suit charges that the defendant violated the Federal Rehabilitation Act, which prohibits discrimination against individuals with handicaps or perceived handicaps. He claimed the defendant treated Doe differently because Doe responded to the physician's questions about marital status by saying he was gay. The plaintiff also alleges that the physician violated the Illinois AIDS Confidentiality Act. The Act does allow certain exceptions for testing without consent, but Nosanchuk said the exceptions did not apply in this case.

While ISMS strongly supports the concept of informed consent for medical treatment, we do not believe that such consent should be subject to government intrusion.

Doe said he learned of the HIV test when he called the physician's receptionist for the results of a kidney test. Doe said he felt that he had been betrayed and that his privacy was invaded, and noted that his ability to obtain health insurance may be compromised. Doe said the doctor told him he orders the test for "all people who have partners."

Speaking through his attorney, Dr. Nold said that he is unable to discuss the case because of laws governing physician-patient confidentiality.

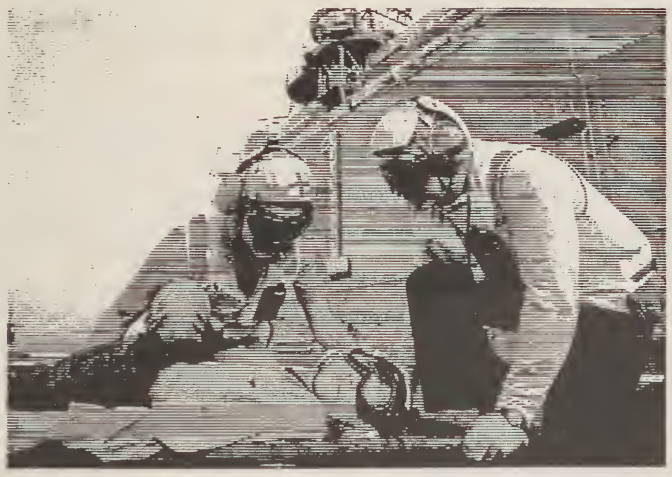
ISMS policy on HIV testing states that "testing for the HIV antibody should be used only in situations that benefit individual patients and the public health." This policy mirrors Illinois law allowing physicians to use their medical judgment in ordering HIV tests. A physician can test patients for HIV if the test is medically indicated to provide appropriate diagnosis and treatment, and if the patient has consented to general medical treatment by that physician.

"The Illinois State Medical Society believes that AIDS is a major public health threat warranting the same medical attention as any other infectious public health hazard," said ISMS President Arthur R. Traugott, MD. "We cannot, however, comment on the individual facts or overall merits of this lawsuit. While ISMS strongly supports the concept of informed consent for medical treatment, we do not believe that such consent should be subject to government intrusion. It is a matter best handled between patients and their physicians." (For more information about ISMS guidelines, see "ISMS provides HIV testing guidelines" on page 4.)

According to AMA policy on HIV testing, pretest and post-test counseling "should be considered an integral component of any testing program. The extent and form of information provided will vary with the circumstances. For example, in the provision of routine testing, counseling need not be as extensive as that rendered in the provision of diagnostic testing.

"All negative test results should be provided in a confidential manner accompanied by information on the meaning of these results and the offer, directly or by referral, of appropriate counseling," the policy continues. "All positive HIV results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social and other consequences of HIV infection." ■

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Credentialing

(Continued from page 1)

our members. This study is a critical first step."

Earlier in the session, two Society-backed bills that would have expanded and codified due process provisions remained deadlocked because of vehement opposition from the Illinois Hospital Association. "ISMS negotiated in good faith with the hospitals, but IHA refused to compromise, demanding that the Society concede more than we were able. We had to draw the line at protecting physicians' due process rights," said ISMS President Arthur R. Traugott, MD. "That's why ISMS finally drafted a resolution directing a study of the issue. It's a logical place to start. If economic credentialing does not exist – as the hospital community claims – the study results should bear out that contention. But I suspect the planning board's research will reinforce what we already know: Physicians throughout the state are experiencing unfair economic credentialing."

Dr. Traugott added that a 1992 Loyola University survey of 1,965 hospital chiefs of staff found that 60 percent of hospitals use economic data to evaluate physicians for medical staff appointments and reappointments. "Although the hospital community refuses to admit that economic credentialing is increasing, these survey results were reported in an American Hospital Association publication, *AHA News*."

AFTER ISMS HELPED draft and introduce S.R. 667, IHA introduced its own resolution calling for a study on the availability and quality of physician services, but failing to address the issue of economic credentialing, Dr. Traugott said. The Senate Executive Committee defeated the IHA measure.

The failed resolution asked the Illinois Department of Public Health to establish a "physician services access task force" to "investigate and assess any effect on the availability and quality of physician services in Illinois by application of economic or financial factors. ..."

"With this resolution, IHA tried again to derail ISMS' efforts to begin developing a basis for due process protection for physicians," Dr. Traugott said, adding that IHA's resolution was misdirected. "The planning board is the appropriate state agency to carry out a study of this nature. Although the board's primary responsibility is administering the state's certificate of need program, that is not its sole responsibility."

The planning board's authority covers a wide range of health care-related planning and cost issues, including the availability of physician services related to certificate of need requests, he said. "IHA officials, themselves, have recognized these broader responsibilities in public testimony during hearings on the rules to implement the Health Care Worker Self Referral Act."

IHA removed its opposition to the ISMS resolution July 2 when the Society verbally agreed to allow the planning board study on economic credentialing to include more than just hospitals, Dr. Traugott said. "ISMS agreed that the whole issue of economic incentives should be studied, especially regarding HMOs, in which the lack of treatment, driven by cost considerations, could be a problem. We also expect the planning board to examine clinics, physician group practices, medical corporations and ambulatory surgical treatment centers, in addition to hospitals."

ACTING UNDER ISMS House of Delegates direction, the Society worked hard throughout the session to pass economic credentialing legislation. Immediately following the House's 1993 Annual Meeting in April, ISMS amended due process protections in economic credentialing onto S.B. 398, sponsored in the House by Rep. Kurt Granberg (D-Carlyle). When IHA balked at this proposal, Democratic leaders in the House of Representatives requested that S.B. 398 be an agreed bill before a floor vote was called. "On the basis of that condition, IHA obviously had no compelling interest to negotiate," Dr. Traugott said. "Consequently, although ISMS compromised on several points, IHA still refused to grant minimum due process rights to medical staff members adversely affected by credentialing decisions. On this point we could not concede more ground. That was the heart of the legislation."

ISMS then amended the conference committee report to S.B. 614 in an attempt to legislate minimum due process, but legislative leaders again called for IHA-ISMS negotiations and an agreed bill prior to House floor consideration. "All we were trying to do through our legislative proposals was expand and codify existing due process provisions for medical staff members in the state's Hospital Licensing Act. We simply wanted to secure fairness in credentialing decisions. When current medical staff members receive an adverse credentialing decision, we believe they should be granted a hearing to present their position. They also should be notified about hospitals' specific reasons for rendering an adverse credentialing decision – whether it's economically motivated or not."

Dr. Traugott pointed to physician contact with legislators this session as a key factor in generating awareness of economic credentialing in the General Assembly. "As with our campaign for tort reform, we must work one step at a time for due process protections," said Dr. Traugott. "We held firmly to our position that any legislation passed should be meaningful. Our first choice would have been passage of an effective legislative remedy this year. However, the resolution offers a strong alternative strategy for continuing to focus attention on this issue and providing the objective documentation essential to ISMS legislative success."

"If the study confirms the concerns about economic credentialing, legislative solutions can be pursued next year," concluded O'Malley. ■



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Vest ruling

(Continued from page 1)

expeditions to get around a malpractice suit." Dr. Vest, his defense counsel and personal attorney were acquitted of contempt charges Feb. 11 when the Fifth District Appellate Court found that the plaintiff's attorney had misused Supreme Court Rule 224 by asking Dr. Vest to describe his treatment of a patient during a deposition. No malpractice suit had been filed at the time of the deposition, and Dr. Vest's attorneys advised him not to answer the question. Dr. Vest and his two attorneys were held in contempt of court on April 2, 1992, and jailed for more than five hours.

Dr. Vest said he doesn't believe this inappropriate form of discovery will be used in the Belleville area again. "They tried this modality, and it failed. I'm happy that it's over."

Bruce Cook, the plaintiff's attorney in the case, had invoked Rule 224 as a means of interrogating Dr. Vest without first obtaining the certificate of merit necessary to file a malpractice suit. But the Supreme Court's denial of Cook's request to appeal underscores the appellate court ruling and its definition of Rule 224: that it may be used only to determine "identification of responsible persons," including names and addresses of individuals who could be named in a future suit.

ISMS and Dr. Vest are "very pleased with the outcome," said ISMS 10th District Trustee Ronald G. Welch, MD, of Belleville. "We had been prepared to comply if we lost, and we hope that the plaintiff is willing to comply with the decision as well. It's a good decision, and we were hoping it would come down this way."

The appellate court's 36-page opinion, handed down in February, blasted Judge James Radcliffe's April 1992 decision to jail the three, specifically noting that it was inappropriate for Radcliffe to detain Dr. Vest, interrupting his patient and hospital schedule.

"The plaintiff cannot appeal to a higher court now," said Charlene Cremeens, Dr. Vest's defense attorney. "The decision puts to rest the problem of physicians being ambushed during depositions when no suit has been filed."

Cook also filed suit in May against St. Elizabeth's Hospital in Belleville, where patient Melvin Roth died of an infection in May 1991. In this latest suit, Cook named all the physicians involved in Roth's treatment as respondents in discovery. Cremeens explained that Cook has six months to depose the physicians and name them as defendants in the suit. ■

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Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)
CONTRAINDICATIONS
Hypersensitivity to any component of this medication.
Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).
Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Prevastatin should be edministered to women of childbeering age only when such patients ere highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.
WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.
As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.
Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.
Skeletal Muscle: Rhebdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with prevastatin end other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Prevastatin therapy should also be temporerily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal feilure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; treuma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**
The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibretes alone may occasionelly be associated with myopathy. The combined use of prevestatin end fibrates should generally be avoided.**
PRECAUTIONS
General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.
Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.
Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t1/2) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.
Informetion for Petients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.
Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.
Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.
Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)
Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.
Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.
Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.
Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.
In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.
Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.
Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.
CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.
A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.
Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.
The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.
A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.
No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae.* In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.
In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.
Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.
Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.
Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).
Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)
ADVERSE REACTIONS
Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.
Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.
The following effects have been reported with drugs in this class:
Skeletal: myopathy, rhabdomyolysis.
Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.
Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.
Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.
Reproductive: gynecomastia, loss of libido, erectile dysfunction.
Eye: progression of cataracts (lens opacities), ophthalmoplegia.
Leboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).
Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.
Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)
OVERDOSAGE
There have been no reports of overdoses with pravastatin.
Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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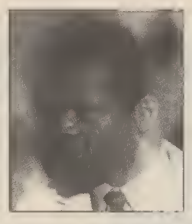
TENDS TO REVIEW COMMITTEES (PAGE 9)

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JULY 30 1993

AWAKENINGS AUTHOR SHARES HIS STORY

PAGE 19



Practicing medicine in the fast lane

PAGE 14

Officials promote urban health care

PUBLIC HEALTH: Health agency representatives from the nation's largest cities met in Chicago to discuss pressing issues. By Anna Brown

[CHICAGO] Deeming it a huge success, the Chicago Department of Health wrapped up its first Big Cities Health Conference June 29. Given the extensive idea sharing during the three-day meeting, Chicago health officials said they hope to make the conference an annual event. Municipal health department leaders from the nation's 25 largest cities discussed urban health issues such as communicable diseases, health promotion and chronic disease prevention, injury control and prevention, and environmental health.

CDOH officials said the meeting highlighted a need for the cities' health leaders to form a more structured group that could provide a stronger voice in the health care reform debate. "This is the beginning of a unit," said John L. Wilhelm, MD, director of CDOH's Bureau of Public Health. "There was a feeling that the group should have been formed a long time ago, that we can create opinions and recommendations."

"It's very different to have health departments talking about what they can do to be more effective," said CDOH Deputy Commissioner Patrick Lenihan. "In the past, public health departments have been mired in traditions with no one talking about the need for change."

The conference was underwritten by pharmaceutical companies, and Dr. Wilhelm said he expects that support to continue. "The time was definitely right to pull it all together. We had a real need to bond. We're no longer too proud to ask for advice."

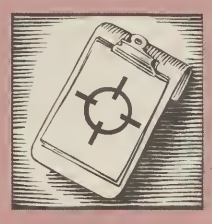
Dr. Wilhelm led the communicable disease program track. He said program participants

(Continued on page 23)

INSIDE

***Petrillo* case affects malpractice litigation in Illinois**

PAGE 10

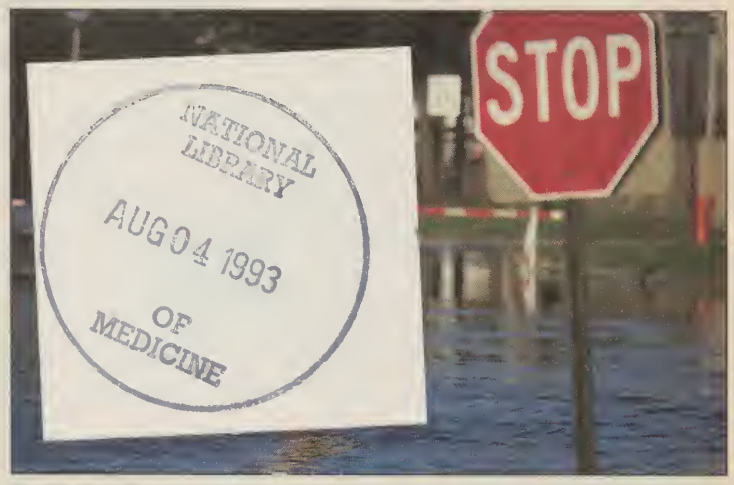


AMA targets health system reform

PAGE 16

DEPARTMENTS

News Briefs.....2
Illinois Watch 5
Commentary.....6
ISMS Board Briefs 8
ISMIE Update 9
Classifieds 17



Ian Solender

The flooded streets in Moline offer a convenient place to go wading for 12-year-old Chris Arrington. But public health officials are cautioning residents to avoid contact with floodwater as much as possible.

Public health concerns rise with floodwaters

DISASTER: Health departments are working overtime to help residents in flooded areas take precautions against possible health hazards. By Gina Kimmey

[SPRINGFIELD] Don't drink the water. That's one of the messages from health departments in downstate Illinois, where flooding rivers and excessive rainfall have devastated crops, driven people from their homes and caused myriad public health risks. The situation led Gov. Jim Edgar earlier this month to ask President Clinton to designate 51 Illinois counties as federal disaster areas, making them eligible for federal emergency disaster loans. As of July 19, 24 counties had been granted disaster-area status.

Throughout the flooded areas, more than 10,000 Illinois residents have been forced to evacuate their homes, said Steve Quigley, Illinois Emergen-

(Continued on page 21)

HHS chief says competition is vital to reform



Shalala

The nation's health care system needs a major overhaul to keep pace with the changing demands of urban America, said Donna Shalala, secretary of the U.S. Department of Health and Human Services. Shalala made her remarks during the Chicago Department of Health's Big Cities Health Conference, June 27-29, attended by health department leaders from the 25 largest U.S. metropolitan areas. During her address, Shalala said too much emphasis has been placed on specialty care at the expense of primary and preventive care.

"We know the issues you deal with – inadequate funding, TB, AIDS, teenage pregnancy, alcohol, tobacco, suicide and homicide," she said. "We are well aware that the public health system needs rebuilding. One thing you can expect from the Clinton administration is a new emphasis and new focus on prevention."

The administration plans to concentrate on encouraging more medical students to choose primary care, she said.

(Continued on page 23)

Medicare takes tougher stance on fraud

INVESTIGATIONS: Physicians are urged to take more responsibility in dealing with labs and DME suppliers. By Anna Brown

[CHICAGO] Federal concerns about Medicare program excesses are prompting carriers to take stronger measures to curb fraud and abuse. Blue Cross and Blue Shield of Illinois, the Medicare Part B carrier in Illinois, is increasing its education efforts by advising medical specialty societies about potential fraud and abuse situations. The most recent schemes uncovered by Blue Cross include some durable medical equipment suppliers and clinical laboratories.

Although physicians try to avoid fraudulent and abusive billing practices, many fear they may be targeted in these crackdowns despite their best efforts to adhere to the law, said John F. Schneider, MD, chairman of the ISMS Third Party Payment Processes Committee. In addition to steering clear of billing schemes, physicians must learn to distinguish the difference between fraud and abuse, Dr. Schneider said.

"Physicians cross the line

(Continued on page 23)

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Red Cross fairs focus on prevention

HEALTH AND SAFETY: The American Red Cross brings health fairs to Chicago. By Anna Brown

[CHICAGO] Kicking off its summer health initiative, the American Red Cross is sponsoring a series of 41 health and safety fairs held in the parking lots of Chicago-area Osco Drug stores. The purpose of the fairs, which target ethnic communities, is to "inform the public and teach preventive medicine," said Martha Raya, publicity director for Health Fair Expo Chicago, the firm coordinating the events.

The first series of fairs provided free screenings and immunizations to Hispanic residents in various sites in and around Aurora. It ended July 18 with a fair in Douglas Park. The second group of fairs, aimed at African-Americans, concluded at Washington Park. The last series, for a general audience, is scheduled to end Aug. 1 at Lincoln Park, Raya said.

Fair workers can't give people all the information they need in one day, said project coordinator Pablo Hernandez, of Health Fair Expo Chicago. "[But] we're trying to supplement and reinforce that they have to take care of themselves and that it doesn't have to cost a lot of money."

Fair participants have included more than 100 hospitals in six counties, along with local businesses and county and city health departments. "It's a nice joint venture between for-profit and nonprofit organizations to provide services to communities," Hernandez said.

Many hospitals provided staff to conduct screenings such as blood pressure, cholesterol, diabetes and lead poisoning checks; cataract and glaucoma tests for the elderly; and general fitness tests.

Doctor's Hospital of Hyde Park agreed to staff three fair sites because it already provides free blood pressure and diabetes screenings to the community, said Mary Tindaric, a hospital spokesperson. "We're trying to help the Red Cross by providing free immunizations."

Although Osco is the project's primary sponsor, Raya said other sponsors include the Tribune Co., American Airlines, MCI and Bally, as well as Chicago radio and television stations such as WMAQ, WOJO, WSNS, WGCI and WLUP.

Last year, the Red Cross held a pilot program in Douglas Park featuring screenings, immunizations and health and safety information. "The attendance was overwhelming," Raya said, noting that the project was expanded this year because of that program's success. "We opened early and ran out of everything. People were nearly breaking the fences to get in."

To date, only Los Angeles and Chicago have adopted the program. The Chicago program will continue next year, Hernandez said. ■



Michael Candee

ISMS PRESIDENT Arthur R. Traugott, MD, spoke to physicians at Hartgrove Hospital in Chicago on June 30. An Urbana psychiatrist, Dr. Traugott talked to the mental health facility's medical staff members about utilization review. During the meeting, he also outlined ISMS House of Delegates policy aimed at alleviating unfair review practices.

Secretary of state seeks advisory board members

[SPRINGFIELD] The Illinois Secretary of State's office is seeking physicians to join its Drivers License Medical Advisory Board. Cardiologists, neurologists and psychiatrists are especially encouraged to apply, but physicians in all specialties are needed.

Physicians on the board review the medical files of driver's license applicants who have medical problems that could make them ineligible to receive a license, said Robert Watkins, assistant counsel to Secretary of State George Ryan. Board members make final decisions on whether applicants should drive or should have limited driving privileges. "Reviewing files can be done in the physician's spare time at home or in the office," Watkins said.

Board members may also be asked to participate in appeals hearings when licenses are denied for medical reasons. Watkins noted, however, that hearings are rare. "We try to settle cases without hearings," he explained, adding that usually the applicant only needs to supply more information to receive the board's approval to drive.

Physician board members are independent contractors of the state and are paid $35 per hour for their services. This fee will increase to $50 per hour next year, Watkins said. Under the Driver's License Medical Review Law of 1992, board members are protected from any liability that could arise from their decisions. The law also contains a confidentiality provision.

"The board does communities and the state a service," Watkins said. "Doctors should review cases when it's medically questionable whether someone should be driving." The current board comprises 12 physicians, but there is no maximum number of physicians that may participate. "We would like as many as possible to join," he said.

Interested physicians should submit a letter to the Secretary of State's Office, General Counsel Roger Bickel, 100 W. Randolph, Fifth Floor, Chicago, IL 60601. For more information, physicians may call the ISMS medical services department at (312) 782-1654 or (800) 782-ISMS. ■

AMA supports EPA passive smoke report

[CHICAGO] The AMA has called a report on the cancer risk from secondhand smoke excellent, well-documented and credible. The study, conducted by the U.S. Environmental Protection Agency, was first released in January. After several tobacco companies filed suit in June and asked a federal judge to order withdrawal of the report, the AMA renewed its support of the study.

"The AMA is willing to file a legal amicus brief in support of the EPA report to confirm that tobacco smoke, inhaled directly or indirectly, is deadly," said Lonnie R. Bristow, MD, chairman of the AMA Board of Trustees.

In the suit, the tobacco companies – including Philip Morris USA, R.J. Reynolds Tobacco Co., and Universal Leaf Tobacco Co. – claim the EPA report isn't supported by science. Dr. Bristow said the tobacco industry claims are unfounded, and added that an industry that kills 450,000 citizens every year cannot be trusted.

"This lawsuit is just another example of tobacco conglomerates blowing smoke in the faces of Americans," he said. "I will personally escort any member of the tobacco industry through the lung cancer unit of any hospital in the country. You need no more evidence of tobacco's deadly intent than to look into the faces of cancer victims and their families." ■

FDA bans over-the-counter anti-smoking aids

[WASHINGTON] Effective Dec. 1, a U.S. Food and Drug Administration ban will prevent any new shipments of over-the-counter smoking deterrents. According to the FDA, the ban will affect approximately 30 types of pills, tablets, lozenges and chewing-gum products now available without a prescription, such as Cigarrest, Bantron and Nikoban. Stores may continue selling the products until their stock is exhausted.

"Smoking is one of the nation's leading public health risks, and we favor any safe and effective method for helping people kick the habit," said FDA Commissioner David Kessler, MD. "However, to reduce smoking-related illnesses and deaths, smoking deterrents have to work."

The ban will not affect the prescription chewing gum Nicorette, nicotine patches or other smoking cessation aids available only with a physician's prescription. ■

HIV care standards being developed

[CHICAGO] The Physicians Association for AIDS Care has contacted thousands of physicians currently treating HIV and AIDS patients to participate in a survey aimed at determining standards for HIV care. The survey results will be used to identify first- and second-line HIV therapies and to collect data to justify reimbursement decisions by third-party payers, the association said.

The survey will be updated annually to track changes in care standards, PAAC said.

Responding physicians will receive a report comparing their responses to those of colleagues in their city and state, as well as nationwide. The survey is sponsored by Abbott Laboratories, Adria Laboratories, Astra Pharmaceuticals, Janssen Pharmaceuticals, Ortho Biotech Inc., Roerig/Pfizer, Sandoz Pharmaceuticals and PAAC members. ■

PHYSICIAN FACTS

The risks of smoking

The following shows that smokers are many times more likely to die of certain diseases than are their nonsmoking counterparts.

Disease	Male smokers	Female smokers
• Coronary heart disease (at age 35-64 years)	2.8 times	3.0 times
• Stroke (at age 35-64)	3.7	4.8
• Emphysema and other chronic/ obstructive lung diseases	9.7	10.5
• Lung cancer	22.4	11.9
• Cancer of the lip, mouth, pharynx	27.5	5.6
• All causes	2.3	1.9

Source: U.S. Surgeon General cited by American Council on Science and Health

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Infant contracts salmonellosis poisoning from formula

PUBLIC HEALTH: The FDA recalls several powdered milk and soy products after confirming cases of salmonella poisoning. By Anna Brown

[OAK PARK] The Cook County Department of Public Health confirmed July 7 that a soy-based powdered infant formula was the source of salmonellosis in a 4-month-old north suburban infant. After two other cases were discovered in Canada, the U.S. Food and Drug Administration recalled milk- and soy-based products, including infant formula, manufactured by a Minnesota food processing plant. The FDA discovered that several products manufactured by Maple Island Inc. were contaminated with salmonella serotype tennessee, a relatively rare organism. Salmonella tennessee was also discovered in the vacuumizer and nitrogen flush box at the plant, according to the FDA.

Cases may have been missed, because the tennessee strain of salmonella ferments lactose and may produce false-negative test results.

Although one case was confirmed in Cook County, other cases may have been missed, because the tennessee strain of salmonella ferments lactose and may produce false-negative test results, said Steve Seweryn, CCDPH communicable disease program coordinator. "At this point we have no other cases identified."

The Cook County infant contracted salmonellosis after drinking Soyalac formula for infants, one of the products the FDA recalled. The other products recalled include Sumacal, a medical food supplement; Propac, a protein supplement; and Medibase, a medical meal replacement.

According to Seweryn, salmonella has been found in dried milk and egg products in the past, so these cases were "not totally unexpected." However, this incidence is different because a non-milk-based formula also became contaminated, he said. Since contamination can occur before or after the product is dried, there is "no good way" to prevent it, Seweryn explained. In addition, he said there is no way to eliminate the salmonella from the product after contamination.

"Manufacturers don't recommend boiling the formula," Seweryn said. "Water sterilization is recommended." The FDA typically monitors safety procedures through quality-control checkpoints during manufacturing, he said.

In a July 2 letter to the Illinois Department of Public Health, the U.S. Centers for Disease Control and Prevention said anyone testing for this salmonella strain should not use routine screening procedures. "Screening procedures must not depend on lactose fermentation," the CDC said. "The reactions of this strain (acid/acid with gas and no H_2S) on triple sugar iron agar (TSI) are atypical of salmonella. Although the strain produces H_2S, it is not detected on TSI, since the acidic conditions caused by the fermentation of lactose inhibit detection of H_2S production. Lysine iron agar (LIA) may be used as a screening medium for this strain in place of TSI, since H_2S produced by lactose-fermenting organisms is detected on LIA. The reactions of this strain on LIA (alkaline/alkaline with H_2S) are typical of salmonella. Automated test systems should be used with caution, since lactose-fermenting salmonella strains tested at CDC in several automated test systems were sometimes incorrectly identified."

IDPH urges infectious disease physicians, hospital laboratory directors and hospital infection control practitioners to reassess any current cases of illness compatible with salmonellosis in individuals who have consumed powdered milk products. They should consider reculturing negative cultures using the testing process recommended by the CDC.

Seweryn suggested that physicians report suspected cases of salmonella more quickly. "Prompt reporting can assist in identifying potential cases much sooner in order to understand the magnitude of the problem." ■

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REPORT FOR *Illinois Physicians*

BENEFIT UPDATE
HOME UTERINE MONITORING

The prevention of premature births is an extremely important issue, both in terms of reducing infant morbidity and mortality, and in avoiding the substantial costs involved in the care of premature infants. One approach introduced over recent years that attempts to reduce the number of premature births is **Home Uterine Activity Monitoring (HUAM)**. These monitoring systems combine the recording of uterine contractions with daily health provider contact or telephone contact to offer patient support and advice. Monitoring recordings are transferred telephonically to a center for evaluation. The goal of these monitoring services is to prevent premature births based on the assumption that women will have an identifiable increase in contractions before the onset of pre-term labor. This early identification will then allow administration of appropriate therapies, such as Tocolysis, that may prevent the onset of the pre-term labor.

Since 1989, when the American Medical Association's Diagnostic and Therapeutic Technology Assessment Committee (1) indicated that the observed reduction in the pre-term rate could not be directly attributed to the monitoring device itself but was probably attributable to the associated increase in nursing contacts that occur in conjunction with the device, Blue Cross and Blue Shield of Illinois (BCBSI) has been considering reimbursement for HUAM on an individual basis. This individual consideration has been provided for patients who were currently classified as having a high risk pregnancy and had a previous documented pre-term birth, or who required monitoring during second trimester bleeding or during tocolytic therapy; only FDA approved devices have been considered for coverage.

In September of 1992, the American College of Obstetricians and Gynecologists (ACOG) (2) issued an update opinion which confirmed the AMA's opinion that there was still insufficient data to validate the claims made for Home Uterine Activity Monitors. The ACOG Committee recommended that HUAM devices remain investigational and not be used for routine clinical use until there was proof of efficacy from a prospective, randomized clinical trial.

In addition, the use of HUAM is extremely expensive. Total charges for monitoring between 24-36 weeks of gestation average $10,000 to $14,000 which includes fees for daily use of the system, for drugs and drug administration, and for provider visits.

While such costs would be a worthwhile investment if premature births were prevented, the weight of evidence in the literature does not substantiate efficacy for the approach. In a recent "Sounding Board" article in the New England Journal of Medicine (3), a group of authors reviewed the existing literature and noted that there was no evidence that the addition of HUAM to frequent provider-initiated contact had any incremental value. Their conclusion was that scientific evidence was insufficient to warrant the clinical use of HUAM except for research purposes.

Based on a re-review of recent data and publications, BCBSI now considers the use of HUAM to be **investigational**, and no longer a covered benefit. This change in benefit will be instituted on July 1,1993.

(1) A.M.A., Diagnostic and Therapeutic Technology Assessment, March, 1989.
(2) Sachs BP, Hellerstein S, Freeman R, et.al., "Home Monitoring of Uterine Activity," NEJM 325:1374-77 (1991).
(3) ACOG Committee Opinion, Number 115, September, 1992.

(Issue: 07/30/93 - BS)

July employee of the month shows communication is key

July Employee of the Month Scott Hallermann is the epitome of physician-first service, said ISMS Vice President of Claims Tim Saunders during the July 12 awards ceremony. Hallermann has been an ISMIE professional liability analyst since July 1992. At the ceremony, he received a plaque and a check for $200.

Hallermann was honored for his actions following a business trip to Freeport. He learned from a concerned physician that the local county medical society had scheduled a meeting to discuss disbanding. When he returned to the office, Hallermann notified his supervisors. An ISMS trustee quickly contacted and revitalized the county medical society. Thanks to Hallermann's alert actions, ISMS helped convince the society to stay together.

Hallermann's nominator lauded his actions, calling them a "good example of teamwork between the Society and [the Exchange]."

"Scott has shown the importance of communication between the different houses of ISMIE and ISMS," Saunders noted.

"It is great to be recognized and rewarded," Hallermann said. "As Tim [Saunders] mentioned, communication is very important. The whole environment here has people in place to get things done. Physician-first service is what it's all about."

All permanent, full-time ISMS employees, with the exception of senior management, are eligible for the Employee of the Month award. Physicians may nominate a staff member by calling the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■



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Hallermann

BECAUSE APPROXIMATELY 60% OF PATIENTS WITH PERSISTENT ANXIETY MAY EXHIBIT DEPRESSIVE SYMPTOMS...[1]

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▲ Relief of anxiety symptoms begins within 1 week, progresses steadily through the fourth week of therapy.[3]

▲ Nonaddictive, no more sedation (10%) than seen with placebo (9%).[4,5]

▲ The more commonly observed untoward events include dizziness (12%), nausea (8%), headache (6%), and nervousness (5%).

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*BuSpar is not indicated for the relief of primary depressive disorder.

Please see references and brief summary on adjacent page.

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References: 1. Data on file, Bristol-Myers Squibb Company. 2. Cohn JB, Bowden CL, Fisher JG, Rodos JJ. Double-blind comparison of buspirone and clorazepate in anxious outpatients with or without depressive symptoms. *Psychopathology.* 1992;25:10-21. 3. Feighner JP, Cohn JB. Analysis of individual symptoms in generalized anxiety—a pooled, multistudy, double-blind evaluation of buspirone. *Neuropsychobiology.* 1989;21:124-130. 4. Lader M. Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med.* 1987;82(suppl 5A):20-26. 5. Newton RE, Marunycz JD, Alderdice MT, Napoliello MJ. Review of the side-effect profile of buspirone. *Am J Med.* 1986;80(suppl 3B):17-21.

Contraindications: Hypersensitivity to buspirone hydrochloride.

Warnings: The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

Precautions: ***General*** *– Interference with cognitive and motor performance:* Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable; therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients: Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdraw patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

Possible concerns related to buspirone's binding to dopamine receptors: Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

Information for Patients – Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding; and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

Drug Interactions – Concomitant use with other CNS active drugs should be approached with caution (see **Warnings**). Concomitant use with trazodone may have caused 3- to 6-fold elevations of SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

Carcinogenesis, Mutagenesis, Impairment of Fertility – No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

Pregnancy: Teratogenic Effects – Pregnancy Category B: Should be used during pregnancy only if clearly needed.

Nursing Mothers – Administration to nursing women should be avoided if clinically possible.

Pediatric Use – The safety and effectiveness have not been determined in individuals below 18 years of age.

Use in the Elderly – No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

Use in Patients with Impaired Hepatic or Renal Function – Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

Adverse Reactions (See also Precautions): ***Commonly Observed*** – The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

Associated with Discontinuation of Treatment – The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

Incidence in Controlled Clinical Trials – Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: *Cardiovascular:* Tachycardia/palpitations 1%. *CNS.* Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. *EENT:* Blurred vision 2%. *Gastrointestinal:* Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. *Musculoskeletal:* Musculoskeletal aches/pains 1%. *Neurological:* Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. *Skin:* Skin rash 1%. *Miscellaneous:* Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

Other Events Observed During the Entire Premarketing Evaluation – The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. *Cardiovascular* – frequent: non-specific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. *Central Nervous System* – frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. *EENT* – frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. *Endocrine* – rare: galactorrhea, thyroid abnormality. *Gastrointestinal* – infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. *Genitourinary* – infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. *Musculoskeletal* – infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. *Neurological* – infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. *Respiratory* – infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. *Sexual Function* – infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. *Skin* – infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. *Clinical Laboratory* – infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. *Miscellaneous* – infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

Postintroduction Clinical Experience – Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

Drug Abuse and Dependence: ***Controlled Substance Class*** – Not a controlled substance.

Physical and Psychological Dependence – Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

Overdosage: ***Signs and Symptoms*** – At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

Recommended Overdosage Treatment – General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

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IDPH mandates second measles dose

IMMUNIZATION: Illinois schoolchildren must receive a second measles vaccine before returning to school this fall. By Gina Kimmey

[SPRINGFIELD] Effective Sept. 1, the Illinois Department of Public Health will require all Illinois students in kindergarten through college to show proof of a second dose of the measles vaccine. Although children routinely receive the vaccine through the MMR – measles, mumps and rubella – immunization they receive at about their first birthday, research has shown that up to 15 percent of children may not develop antibodies to the illness after the first dose.

Everyone born before 1957 was exposed to the disease and therefore developed an immunity to it, according to IDPH. But individuals born after 1957 may still be susceptible, even after one immunization.

Illinois experienced a severe measles outbreak from 1989 through 1990. Statewide, 3,279 cases were reported in 1989, with 10 fatalities; in 1990, 1,348 cases were reported. Only 66 measles cases had been reported the year before the outbreak.

For several years prior to 1989, many groups – including the American Academy of Pediatrics – recommended the second vaccination, but the legislature did not appropriate funds for the vaccine until the 1989 outbreak. That appropriation enabled IDPH to require the second dose. In 1991, the most recent year for which figures are available, 26 measles cases were reported in Illinois, according to IDPH.

Terry F. Hatch, MD, an Urbana pediatrician and president of the Illinois Chapter of the American Academy of Pediatrics, said he supports the second-dose requirement. "Unfortunately the [MMR] shot doesn't convey consistent vaccination, and in a number of people the vaccine needs boosting." Measles is a systemic illness characterized by a high fever and sometimes pneumonia, he said, adding that it can be more severe in older patients. "Over the years, we have benefited from the use of vaccines, but every so often there is a resurgence of an illness that can become very serious for those who aren't properly immunized."

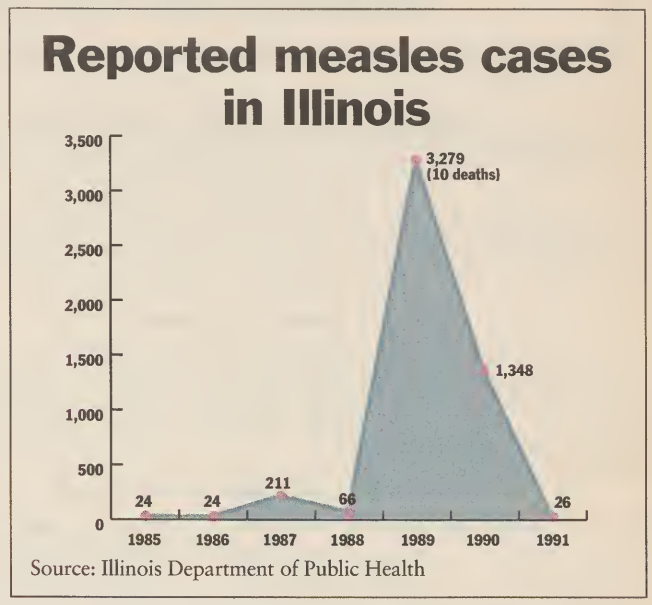
> *Every so often there is a resurgence of an illness that can become very serious for those who aren't properly immunized.*

IDPH said the state is giving schools a strong incentive to spread the word about the new vaccine requirement: Schools with less than 90-percent compliance will lose critical state funding. Students who do not show proof of a second vaccination will not be allowed in the classroom, according to IDPH.

The department recommends that students receiving a second dose should opt for a second MMR vaccine, instead of just a measles shot. According to IDPH, research may show that a percentage of people aren't developing antibodies to mumps or rubella either, and it is more cost-effective to receive a second dose of MMR – one shot – instead of paying for two or three shots and separate physician office visits.

The Cook County Department of Public Health estimates that in suburban Cook County alone there are about 200,000 children who need a second measles vaccination. The department is urging parents to have their children immunized before the end-of-summer rush.

"Our immunization clinics are always the busiest in July, August and September," said Kay Knudsen, RN, the department's immunization coordinator. "This new requirement will add an extra burden on public health immunization clinics. If people do not act now, we very well could see five- to six-hour waits in our clinics. We are urging parents to use their private doctors, HMOs, and township and community clinics as soon as possible to avoid long waits and possible exclusion from school in the fall." ■



Physician lecture program scheduled

COUNTY UPDATE: The Effingham County Medical Society is sponsoring a daylong program featuring international health care speakers. By Anna Brown

[EFFINGHAM] Continuing its effort to become more visible in the community, the Effingham County Medical Society is offering a lecture program Aug. 14 at St. Anthony Memorial Hospital in Effingham. The medical society worked with local physicians to develop the program as a "professional and social opportunity for physicians" in surrounding communities, said Carol Gapsis, the society's executive director. Invitations were sent to physicians in eight nearby counties, but the program is open to all physicians, she said.

The seminar will include a discussion of the German and Canadian health care delivery systems, with lectures by Austrian and Canadian physicians. ISMS Seventh District Trustee Ronald L. Ruecker, MD, will present an overview of the health care reform plan adopted in principle this year by the ISMS House of Delegates. Also covered will be clinical topics such as hypertension, diabetes, liver transplants and the medical management of Alzheimer's disease.

Scheduled speakers will include John Poterucha, MD, from the Mayo Clinic; Julio Santiago, MD, from St. Louis Children's Hospital; and George T. Grossberg, MD, from the St. Louis University School of Medicine's division of geriatrics. H. Ross Perot was also invited to speak but will not commit to a speaking engagement until two weeks before the event.

Gapsis said many physicians have already registered for the program, including doctors from Champaign-Urbana, Vandalia, Mt. Vernon, Decatur and Effingham, as well as several from Michigan, Indiana and Iowa. Funding for the program was donated by the community and pharmaceutical companies, Gapsis said. A concurrent program will also be held for physicians' spouses.

"[The program is] going to be the biggest medical event here ever," said Peter Kollinger, MD, an Effingham physician who helped organize the program. He added that the Effingham medical community is trying to expand the resources it offers. The community already supports "all kinds of specialists," he said.

"We're hoping to do something like this every year," Gapsis said, adding that the society intends to develop another program for next spring.

Following the morning program, the society is hosting an afternoon social at Lake Sara to "promote camaraderie" among physicians, Gapsis said.

Physicians interested in attending the lecture program should contact the medical society at (217) 342-6743. ■

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EDITORIAL

Don't wait until it's too late for license renewal

If you haven't thought about renewing your three-year Illinois medical and controlled substance licenses or if you put renewal on the back burner, now is the time to get to it. The deadline is July 31.

To date, less than 50 percent of the forms have been processed, and many packets from IDPR have been returned because of incorrect addresses. That means that in the coming weeks, IDPR will be processing the majority of physicians' renewal applications, possibly resulting in bottlenecks.

Consider the consequences of failing to renew your license. Physicians who fail to renew are technically practicing without a license and could face disciplinary action by IDPR. In addition, some hospitals, clinics and groups will not allow physicians to practice unless they have a current medical license in hand.

Practicing without a license also jeopardizes liability coverage. Exchange policyholders will have no medical malpractice coverage while they are practicing without a license. This could create a coverage gap with dire consequences if a claim is filed, because physicians would have no protection for their personal assets if an adverse judgment was entered against them. It would be difficult, if not impossible, to obtain liability insurance from any company for the time physicians practice without a license.

Controlled substance licenses for physicians must also be renewed by July 31, according to IDPR. New rules regarding physicians' controlled substance licenses will be enforced this renewal cycle. The department stressed that all physicians who prescribe controlled substances must apply for at least one license, even if they do not store drugs in their office.

Renewed controlled substance licenses cost $15; an additional $15 fee is required for each practice location that requires a renewal license. These fees are in addition to the $300 ($600 for out-of-state physicians) medical license fee.

In 1991, ISMS fought for an extension in the licensing renewal process, to allow physicians some latitude in the face of disciplinary action and gaps in malpractice insurance. After July 31, license renewal fees jump to $400 for a medical license and $700 for out-of-state licenses. Don't delay. Act now to renew these necessary licenses. You don't want to wait and take a chance on something as important as your medical license. Once the 90-day extension is past, you face very serious consequences if you are practicing medicine without a valid license.

Renewal packets were mailed to all Illinois physicians in June. If you have not received yours, you should immediately contact IDPR at (217) 782-0458. You have too much at stake to wait.

PRESIDENT'S LETTER

Changes coming in health care delivery



By Arthur R. Traugott, MD

There has been much speculation about the future of our health care system. Although we don't know the specifics of President Clinton's health reform plan, one thing is certain: The way physicians practice medicine is going to change dramatically. Specifically, the president is leaning toward managed care, emphasizing preventive and primary care.

Historically, our health care system has not encouraged prevention. Traditional health plans have covered medical care only when patients are sick. Often, patients must foot the bill for routine checkups and most preventive services. As a result, many don't seek preventive care. In effect, our system has rewarded patients for being sick and penalized them for taking steps to remain healthy. Recently, we have come to realize how costly and serious this approach can be.

I'll never forget the story a colleague told me a few years ago about a middle-aged woman he treated. She came to him with a lump in her breast, and she had never received a mammogram because she was a Medicaid recipient and the procedure wasn't covered. By the time she discovered the lump and saw the doctor, it was too late. She required a radical mastectomy, and her chances of survival were not good. Of course, early intervention would have improved her quality of life and, most important, increased her hope for survival.

For the medical profession, this new emphasis on prevention will shift our reliance away from sophisticated, specialized care to more cost-effective primary care.

For the medical profession, this new emphasis on prevention will shift our reliance away from sophisticated, specialized care to more cost-effective primary care. What we see happening is a team approach to delivering medical care. In some communities, this approach is already in practice. More and more, physicians are employing nurse practitioners and physician assistants. These practitioners, acting under the direction of a physician, may take histories and provide follow-up care such as giving shots, counseling patients on lifestyle changes and explaining how to take medication.

Under a new health care system, these practitioners will likely have an expanded role. But there are limitations surrounding the use of nurse practitioners and physician assistants. Although they may be appropriate for providing preliminary and follow-up care, they do not have the educational depth necessary to identify and diagnose complex underlying medical conditions. If untreated, such conditions could become deadly.

Certified nurse midwives provide valuable prenatal and delivery services for low-risk cases. But a low-risk delivery can turn into an emergency situation in a matter of seconds. The mother could begin to hemorrhage. Or the oxygen flow to the baby could be cut off. In such situations, nurse midwives would not have the experience or expertise necessary to save the mother's or the baby's life. That is why today, nurse practitioners work under the supervision of highly trained physicians.

By working together as a team, physicians and other health care practitioners can expand access to basic medical care, especially in areas where the physician shortage is the greatest, and deliver care cost-effectively.



"... Tonight's guest will demonstrate graphically the impact of taxes, government regulations and litigation on the practicing physician. ..."

GUEST EDITORIAL

Tobacco campaigns add up to hypocrisy

By Richard Roeper

You have to admire the sheer determination and dedication of the great American cigarette companies. Undaunted by overwhelming evidence that links smoking to a variety of horrific diseases and unshaken by the hundreds of thousands of smoking-related deaths that occur every year, they continue to pursue their mission in life, which is to get you to smoke. And if you already smoke, they want you to smoke more.

What makes it easy for cigarette companies and their advertising agencies is a cheerfully evil willingness to lie through their teeth and shroud their campaigns in shameless hypocrisy.

For instance, that Joe Camel cartoon character guy. Surveys have shown he's as recognizable to kids as Barney the Dinosaur and Mickey Mouse, but the people at R.J. Reynolds continue to maintain that Joe Camel isn't designed to appeal to youngsters, not at all. Hey, they don't want young people to smoke! That would be wrong. They're perfectly content to serve the millions of adult smokers already out there – and when those adults die off, they'll gladly go out of business.

What a great bunch of humanitarians.

Equaling R.J. Reynolds' high-minded refusal to recruit youngsters is Philip Morris' deep commitment to the physical fitness of their adult customers. For evidence of that, one need only check out the new merchandise catalog from the "Marlboro Adventure Team."

Yes, the same cigarette manufacturer that gave us the heroic Marlboro Man (until he died of cancer) now gives us the opportunity to buy outdoorsy clothes and gadgetry, all emblazoned with the famous Marlboro logo.

From the opening page of the catalog: "This is THE WEST, where the Marlboro Adventure Team plays. Where Hell Canyon and Lizard Rock aren't just names on a map. They're adventures waiting to happen."

Also from the opening page of the catalog: "SURGEON GENERAL'S WARNING: Smoking Causes Lung Cancer, Heart Disease, Emphysema, And May Complicate Pregnancy."

Well, what the heck, adventure can't last forever.

The slick, full-color brochure showcases items such as a heavy-duty sleeping bag, river shorts and rain gear, a backpack, a Swiss Army knife, a combination flashlight/emergency beacon/radio in weather-resistant casing, even an inflatable two-person kayak (ashtray not included).

How do the prices compare with your local sporting goods store? That's the best part of the deal – your money is no good with Marlboro. The only way you can obtain this merchandise is by piling up "Adventure Team Miles."

It works just like a frequent flier program, but in this case you accumulate miles by smoking like a chimney.

"Here's how to get the gear," reads the catalog copy. "Collect Adventure Team Mile UPCs on specially marked Marlboro packs to get your Marlboro Adventure Team Gear. Each UPC is worth 5 Miles. For example, to get the Red Dust Shirt, you'd need 360 Miles, which equals 72 packs.

"Supply is limited, so start saving now," urges the ad copy. "Share the experience with the Team. Get the Miles to get the gear made for adventure."

The item I've got my designs on is the 4X4 All-Weather Lighter, priced at only 150 miles – which translates to a mere 30 packs, a meager 600 cigarettes. Available in red, yellow or black, the lighter features a "WEATHERPROOF FLAME for light-ups in hailstorms, snow squalls, dust devils and typhoons."

Yeah, but will it work in Chicago in June?

What's most amazing to me is that apparently nobody connected with the Marlboro Adventure Team saw the macabre irony in offering all these fitness-related, mountain-climbing type items to customers on a need-to-smoke basis. I mean, the Sevylor Chute Runner kayak is priced at 1,800 miles – that's 360 packs of cigarettes. By the time you pile up enough miles to buy the thing, you'd be too short of breath to get it in the water.

Richard Roeper is a regular columnist for the Chicago Sun-Times.

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GUEST EDITORIAL

No longer green, not quite jaded

By Sen. Peter G. Fitzgerald

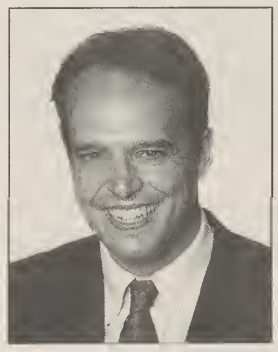
The day after I was sworn in as a State Senator, I was at my desk in the Capitol Building when a lobbyist came in with one of his clients. The lobbyist, whom I knew well, asked me to be the chief Senate sponsor of a bill which he described as "consumer protection" legislation. When I asked him to be more specific, he explained that his bill would require insurance companies to photograph cars before insuring them. Because I was the Vice Chairman of the Senate Insurance Committee, he wanted my sponsorship.

I confessed I was at a loss to understand why he described his bill as "consumer protection" legislation. His answer was oblique, but something to the effect that, if insurance companies took pictures of cars before insuring them, it might be easier to prevent frauds and find stolen cars.

Then I asked the lobbyist who his client was. He informed me that the gentleman at his side was a vice president of a major camera manufacturing company which, incidentally, happened to manufacture the very equipment that would make this vast catalog of cars a cinch. It was at this point that a little alarm went off in my head: the proposed "consumer protection" legislation was little more than a bill to require insurance companies to purchase the product of a particular camera manufacturer.

While I suppose I wasn't that surprised that a lobbyist would have the courage, or gall, to ask the legislature to enact an artificial market, I was surprised that neither of my guests looked the least bit sheepish. I shouldn't have been. What these two gentlemen proposed was nothing out of the ordinary. In the next few months, the identical tableau repeated itself over and over in my office – only the names and the faces changed.

The essential nature of lawmaking in Springfield can be stated simply, if inelegantly: by and large, for any given piece of legislation, some industry, labor union, or group of interested parties stands to make money or benefit, while some other industry, labor union, or group of interested parties stands to lose. If this fight over the spoils were blunt, and the interests were squarely arrayed, the process by which we govern might not rankle as it does. But the insidious aspect of the system is the inevitable rhetoric that cloaks legislation and debate. In the above example, camera protection gets dressed up as "consumer protection." Elsewhere, subsidies are "investments," taxes are "contributions," debt is "lapsed-period spending," and lobbying by the Illinois Education Association – the teachers' union – is "for the kids' sake." In a classic example of Springfield doublespeak, I was greeted in the rotunda one morning by picketers from the AFL-CIO carrying signs emblazoned "Special Interests Make Me Sick." The irony was apparently lost on them.



Sen. Fitzgerald, JD, *is a freshman Republican state senator from Palatine.*

Observers have repeatedly asked me if I am disheartened, as a freshman, by the plethora of organizations, formal and informal, pushing their individual agendas. I think, not entirely. James Madison, the principal formulator of U.S. Constitutional doctrine, theorized that it would be impossible in a democracy to prevent the rise of "factions" (what today we call "special interests") because people, by nature, would always act in their respective self-interests. Instead of eliminating factions, Madison sought to construct a system in which no faction could take unilateral control. His idea was to create a system of checks and balances so broad that all would flourish, and none would dominate.

Springfield is Madisonian theory made flesh. We hear the clamor of all: labor and business; taxpayers and tax-consumers; Chicago, the suburbs, and downstate. And although this system is arguably divisive, inefficient and static – often producing the infamous "gridlock" – it is nevertheless fundamentally democratic and reflective of the philosophy of the Founders.

The system works, however, only as long as the interests at stake are honestly stated. Thus arises my theory of the legislator as onion peeler: it becomes my job, in my office in Springfield, to strip away the rhetoric of debate, layer by layer, exposing the interests in question, the winners and losers, the impact on my individual constituency, and even the impact on the admittedly amorphous "public as a whole." It is painstaking. It is tedious. It often involves a tremendous amount of dreary research. But it is phenomenally important. If we do not make an attempt to stare these issues directly in the face, strip them to their bones, and place them, however loosely, in a broader philosophical and ideological context, we risk public policy that is disjointed, incoherent, and fundamentally dishonest.

To my friends at the Illinois State Medical Society who have helped a very green Senator with much advice, some of which I've followed and some of which I haven't, thank you. I'll continue to peel my onions and keep you informed.

Illinois Medicine *is looking for physician-written guest editorials on health care issues. If you have an idea you think might interest your colleagues around the state, contact* Illinois Medicine *at (312) 782-1654, extension 1261, or (800) 782-ISMS.*

ISMS Board Briefs

The ISMS Board of Trustees met June 19 at the ISMS Conference Complex in Chicago. The following are highlights of the board's actions.

ISMS reform proposals promoted

ISMS is developing public relations activities to promote the Society's policies and positions on health care system reform. The public relations effort will be led by ISMS President-elect Alan M. Roman, MD, and coordinated by a three-council subcommittee. The subcommittee will also spread the message that a cap on noneconomic damages in professional liability cases is an integral part of any health system reform. Although ISMS' own health care reform proposals are still being refined, the Public Relations Committee for Health Reform will help position the Society as the reform debate heats up in Illinois and nationwide.

Campaign against family violence planned

ISMS will support the ISMS Alliance (formerly the Auxiliary) in its efforts to better educate physicians about the costs of family violence. The Alliance will focus on the different types of violence that routinely occur in U.S. homes, such as physical, emotional and sexual abuse. As part of the program, the Alliance will provide physicians information to help them identify cases of family violence and resources for their patients. In addition, Illinois physicians and Alliance members will be encouraged to join the National Coalition of Physicians Against Family Violence.

Organized medicine speaks out against enterprise liability

In a letter to the White House, ISMS joined forces with the AMA and state and specialty societies to support enacting meaningful tort reform. As stated in the letter, organized medicine opposes a move to enterprise or organizational liability. Organized medicine and other opponents of enterprise liability believe the concept is unproven and would not reduce malpractice costs or the time physicians waste defending nonmeritorious lawsuits. They also contend that an enterprise-liability system could encourage frivolous lawsuits, since suits would be filed against health care entities and patients might be inclined to sue organizations more than their personal physicians. Enterprise liability could also lead to increased economic credentialing of physicians, particularly doctors who practice in high-risk specialties and tend to be sued more often. Most important, physicians would not control critical settle-or-defend decisions; insurers or providers could choose to settle cases that physicians or hospitals consider defensible.

ISMS to communicate about IPLAN

ISMS will inform county medical societies about an Illinois Department of Public Health initiative called the Illinois Project for Local Assessment of Needs, or IPLAN. The program requires local health departments to prioritize their public health needs, develop action plans for addressing those needs and submit their action plans to IDPH. By participating in this program, physicians can provide valuable input about local public health programs and policies, and boost communication between doctors and public health administrators.

Regional speaker training sessions approved

Illinois physicians will be invited to participate in regional speaker training this fall. To help prepare participants for media interviews and public speaking engagements, sessions will cover ISMS positions on such issues as health system and tort reform.

ISMS hears from specialties

In ISMS' ongoing effort to establish dialogues with medical specialty societies, the board heard reports from the Illinois Radiological Society and the Illinois Psychiatric Society. IRS President Jerry P. Petasnick, MD, and IPS President Robert C. Powell, MD, PhD, presented their organizations' major goals and concerns.

IDPH alerted to nursing home surveyor problems

Nursing home surveyors should not order tests without a physician's prior knowledge and approval, according to IDPH. The department is investigating this and other practices following ISMS House of Delegates' action requesting IDPH to evaluate the quality of nursing home surveys. The House action stemmed from physician concern about inconsistencies in department surveyors' interpretations of state nursing home regulations. ■

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MEDICAL LEGAL GUIDELINES

PAGE 11

ISMIE Update

Case in Point looks at the *Petrillo* case

PAGE 10

Focus on service extends to review committees

PROGRESS: The Exchange takes another step underscoring its commitment to put physician service first. By Gina Kimmey

[CHICAGO] The latest wave of reorganization spurred by the Physician-First Service initiative restructured the Exchange's Physician Review Committee and Physician Review and Evaluation Panel. In keeping with the Exchange philosophy that the provision of malpractice insurance is a service, not a product, the committees have been modified to meet the evolving needs of physician policyholders. A continual concern is to help policyholders improve the quality of care through risk management activities. To help accomplish this goal, Exchange risk management experts offer input about possible educational activities that might benefit physicians.

"Our policyholders have been very satisfied with the company's sound fiscal condition, aggressive defense of claims, and tough but fair underwriting practices," said Harold L. Jensen, MD, chairman of the Exchange Board of Governors. "The changes implemented through the service initiative are intended to make a good company even better by ensuring that decisions are made with the best interest of each physician owner in mind."

EVERY EXCHANGE malpractice case requires a settle-or-defend decision. The Physician Review Committee is responsible for making these difficult and sensitive determinations. Through the service initiative, the PRC will operate under a new philosophy. "In the past, every case was considered defensible until proved otherwise. Now each case is considered neutral until a thorough physician review has been completed," explained Alfred J. Clementi, MD, chairman of the ISMIS Board of Directors. All physician PRC members are medical liability specialists and are charged with evaluating the medical, legal and business aspects of each case. The majority of Exchange cases are considered defensible, Dr. Clementi noted.

"When a medical malpractice suit is filed, it's not only the named defendant who is being sued, but the whole company," Dr. Jensen said. "The decision to settle or defend a suit must be made with all the physician policyholders in mind. Are we doing a physician a favor by defending an indefensible case? No. It's the responsibility of the members of PRC to consider how this decision will affect the other 10,000-plus physician insureds as well."

If physicians disagree with PRC's settle-defend decision, they may request a personal appearance with the committee. A personal appearance allows insured physicians to present their reasons for believing PRC made an incorrect decision. Although PRC makes the final settle-or-defend determination, information exchanged during personal appearances can be educational for the committee as well as physician policyholders. This benefit distinguishes the Exchange from commercial malpractice insurance carriers.

Spanning 19 specialties and six counties, the committee's membership includes nine physician voting members and 14 physician consultants. Increased staffing will allow the committee to expedite reviews and expand policyholder representation throughout the state. As always, all cases will be reviewed more than once, and no case will go to trial if more than two years have elapsed since it was last reviewed, Dr. Jensen stressed.

Working under the premise

(Continued on page 12)

Leading causes of ISMIE drug-related claims

- **Incomplete drug history**
- **Failure to document prescriptions, allergies and instructions given to patients**
- **Prescription renewal by staff without physician approval**
- **Inadequate patient instruction**
- **Dangerous drug interactions**
- **Wrong drug dosage**

Source: Illinois State Medical Inter-Insurance Exchange

MALPRACTICE ROUNDUP

Surgeons responsible for postoperative care

A ruling by the Florida Board of Medicine has been upheld by Florida's First District Court of Appeals. The ruling states that nonphysician practitioners – including optometrists and nurses – lack legal standing to challenge the development of surgical standards under the postoperative care rule. According to this rule, surgeons carry the responsibility for managing postsurgical care, and delegation of that care to other health care practitioners is permitted only under specific circumstances. For example, postoperative care can be delegated only to practitioners supervised by the surgeon or to licensed doctors of medicine or osteopathy who have equivalent training, or physicians in training.

The medical board said only the physician who performs the surgery has the training, experience and licensure to provide all possible aspects of ophthalmic postoperative care. The board ruling also states that the Florida Board of Optometry and the Florida Optometric Association failed to prove they would be harmed by the rule.

"This rule puts in writing a standard of care that is observed by most surgeons and has prevailed throughout the history of surgery," said H. Dunbar Hoskins Jr., MD, executive vice president of the American Academy of Ophthalmology. "It helps us remember our responsibilities to our patients at a time when there is increasing pressure to compromise on quality of care issues." ■

$1.5 million awarded for unnecessary C-section

In what is believed to be one of the first cases of its kind, a Boston jury awarded $1.5 million to a woman who claimed doctors performed an unnecessary cesarean section against her wishes. Malpractice suits involving C-sections usually allege that a physician failed to perform the procedure when needed, resulting in damage to the baby, said a lawyer for the American College of Obstetricians and Gynecologists.

As reported in the *Chicago Tribune*, the patient claimed that the 1985 surgery set off a dormant intestinal condition that required her to be hospitalized for nearly a year. The child, the second delivered to the patient by cesarean, is now a healthy 7-year-old girl. Lawyers for the physicians contended the surgery was necessary because the patient was late in delivering. Defense attorneys also argued that in 1985 many obstetricians would have been reluctant to help a woman deliver vaginally if she had previously had a cesarean. ■

Case in Point

Petrillo case affects malpractice litigation in Illinois

By Kathleen Furore

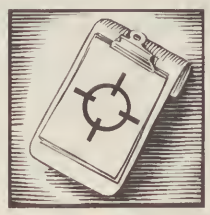
In 1986, the Illinois Court of Appeals handed down a ruling in the landmark First District case *Petrillo vs. Syntex Laboratories, Inc.* The ruling barred physicians and defense attorneys involved in medical malpractice litigation from communicating ex parte (without the plaintiff's expressed consent and outside the presence of the plaintiff's attorney) with subsequent treating physicians. This decision has created a problem for physicians because of its one-sidedness. Plaintiffs' attorneys *can* talk to subsequent treating physicians without reprisals.

Case #1

The *Petrillo* case in brief: During a products liability trial involving the distributor of two baby formulas that allegedly harmed infants, the defense attorney mentioned he had communicated ex parte with one of the plaintiff's subsequent treating physicians.

The plaintiff's attorney objected and was granted a motion prohibiting the defense attorney – as well as the distributor's representatives – from communicating ex parte with any of the plaintiff's subsequent treating physicians. Contending the motion had been granted in error, the defense attorney said he would violate the order and consequently was held in contempt of court.

During the defense attorney's appeal, the court ruled that permitting defense counsel to communicate ex parte with a patient's subsequent care giver violates the "confidential and fiduciary nature of the physician-patient relationship, which is well-recognized by the courts in Illinois." It also ruled that, although the plaintiff "implicitly consents to the release of otherwise privileged or confidential medical information related to the condition at issue, the waiver is necessarily limited to formal methods of discovery to protect the sanctity of the physician-patient relationship."



Case #2

The case in brief: During the trial of a doctor sued by a 40-year-old male with severe neurological injuries (allegedly caused by negligent postoperative care), the defense attorney called one of the plaintiff's subsequent treating physicians as a witness. The plaintiff asked the court to bar the testimony, claiming that ex parte communication had occurred in violation of the physician-patient privilege. The motion was denied, and the trial ended with a verdict for the defense.

When the verdict was appealed, the plaintiff's attorney argued that the testimony should have been barred based on the violation of the physician-patient privilege. Even though the case was initially decided before *Petrillo,* the court stated that the *Petrillo* decision would have been rendered meaningless if the information obtained from "such unauthorized interviews" had been introduced. Consequently, the court held that "barring the testimony of a plaintiff's treating physician was an appropriate sanction for such a violation."

A new trial was granted, but the defense was prohibited from calling the subsequent treating physician on retrial and had to limit contact to formal discovery only.

Case #3

The case in brief: A woman with a history of fibrocystic breast disease died of breast cancer, which her primary physician had not detected. Her husband sued the primary physician for medical negligence in failing to diagnose and treat the cancer. A second surgeon, who later diagnosed the breast cancer, was contacted by a plaintiff's attorney to be interviewed about the case. A defense attorney sat in on the interview; that same defense attorney later represented the primary physician. The second surgeon testified at trial that the primary physician (who died before the case came to trial) did not operate outside the standard of care. The jury ruled in favor of the defense.

The plaintiff's attorney appealed, saying the ex parte conversation (which occurred in the late 1970s) violated the *Petrillo* decision of 1986. Once again, the court decided to reverse the decision and remand the case to the trial court, prohibiting any testimony from the subsequent treating physician.

The points these cases make: According to malpractice litigation specialist Jeffrey Glass, of Hinshaw & Culbertson, and John V. Smith II, a medical malpractice litigator with Pretzel & Stouffer, these cases illustrate how speaking with subsequent treating physicians can damage a physician's defense. They also show the extent to which the courts have gone to uphold the physician-patient privilege as defined in *Petrillo.*

"The basic premise of the *Petrillo* doctrine intends to preserve the confidentiality between the treating physician and the patient," Glass explained. "*Petrillo* fairly clearly established that [defense] counsel can't contact a treating doctor directly regarding the plaintiff's condition, and that only formal methods of discovery, such as depositions and subpoenas for medical records, can be employed. But more recently, the courts have used the reasoning behind *Petrillo* to bar contact by others, including defendant doctors."

Some facts in the breast cancer case show the extent to which a court will go to enforce the *Petrillo* rule, Smith said. First, the contacts occurred before any Illinois decisions ruled that an attorney couldn't speak with subsequent treating physicians. Second, the plaintiff's attorney never alleged that subsequent treaters disclosed anything that shouldn't have been disclosed. And third, the plaintiff's attorney admitted that the defense attorney who met with the doctor did absolutely nothing wrong. Smith said the appellate court's concern was that the *Petrillo* ruling would be weakened if the verdict in the breast cancer case was not overturned.

Smith also noted that the physician-patient privilege statute – enacted in Illinois in 1959 – lists eight exceptions expressly limiting the privilege. According to the statute, the privilege is waived in all civil suits in which patients place their physical or mental condition at issue by alleging medical malpractice.

Exchange professional liability analysts say that in spite of the exceptions, the state's appellate courts have even expanded the *Petrillo* rule in subsequent cases, precluding ex parte communications between a defendant hospital and its own staff doctors who treated the plaintiff, between the defense and a nurse present during surgery performed on a plaintiff by a defendant doctor, and between the defense and a nonphysician rehabilitation counselor.

To ensure that physicians maximize their defense in malpractice litigation, Glass, Smith and malpractice litigation specialists offered these recommendations:

• Don't speak to subsequent treating physicians after a lawsuit has been filed. "Having a physician contact a subsequent treating physician creates just as unfavorable a situation as if an attorney had initiated the communication," Smith said.

(Continued on page 13)

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

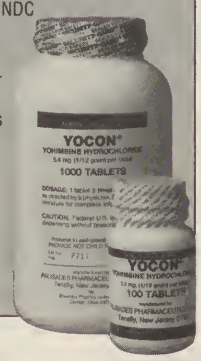
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Guidelines for subpoenas, surrogates discussed

MEDICAL LEGAL GUIDELINES

In the context of medical malpractice litigation, subpoenas are generally court orders issued by a clerk of the court that do not require the signature of any party. They may direct physicians to testify at a deposition or trial regarding a patient, former patient or another doctor's practices. Subpoenas may also request certain documents. Physicians who receive a subpoena must respond in some acceptable way. If they fail to respond, they may be at risk for being held in contempt of court.

When subpoenas call for testimony, physicians do not necessarily have to appear at the time scheduled. Physicians or their attorney may contact the lawyer who caused the subpoena to be issued to arrange a convenient date and time for the doctor to testify. If no scheduling agreement can be reached or if they object to appearing, physicians should consult their personal attorney to suppress the subpoena or petition the court for a protective order.

If subpoenas request certain documents but releasing them would violate the physician-patient privilege, physicians must file written objections with the court. However, if patients have filed a lawsuit raising their physical condition or treatment as an issue, the law generally considers that they have waived that privilege. Physicians should obtain a written waiver from patients before turning over their files. Usually when patients put their physical condition at issue by filing suit, their medical records, which would otherwise be considered confidential, become subject to discovery pursuant to their consent.

Most subpoenas requesting documents are general and do not define the specific documents demanded. In such cases, physicians or their attorney should contact the lawyer who filed the subpoena to try to reach an agreement that would modify the request. If no agreement is reached, physicians may go to court to get the subpoena suppressed. The court may, in turn, limit, modify or quash a subpoena that is unduly burdensome.

Physicians often receive subpoenas for original records, but if documents or records can be authenticated by testimony, photocopies of medical records may be submitted instead of originals.

Physicians should direct any specific questions about subpoenas to their own attorneys.

SURROGATES AND THEIR ROLE in health care decision making, are addressed in the Health Care Surrogate Act [755 ILCS 40/1 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 110 1/2, pars. 851-1 – 851-55]. The Act was passed by the Illinois General Assembly in 1991 in response to increasing involvement by Illinois courts in life-sustaining medical treatment decisions. The Act details standards for making life-sustaining treatment decisions for individuals who lack decision-making capacity, suffer from a terminal condition and have not executed a durable power of attorney for health care or a living will.

For more information on advance directives, physicians should consult the ISMS medical legal guidelines on durable power of attorney and living wills that discuss the Powers of Attorney for Health Care Law [755 ILCS 45/4-1 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 110 1/2, pars. 804-1 – 804-12], and the Illinois Living Will Act [755 ILCS 35/1 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 110 1/2, pars. 701 – 710].

Specific physician responsibilities under the Health Care Surrogate Act are outlined in the ISMS brochures "A Physician's Guide to Advance Directives," "Health Care Surrogates" and "A Personal Decision." "A Physician's Guide to Advance Directives" is an easy-to-use reference for physicians that presents information in a question-and-answer format. "A Personal Decision" contains patient-oriented materials and may be distributed as a reference for patients. ■

Editor's note: This is part of a series on medical-legal issues written by the ISMS Medical Legal Council. These guidelines do not necessarily represent ISMS policy. They address legal concerns that physicians commonly express to ISMS and are intended to serve as only a guide for physicians, not specific legal advice.

Medication seminar tapes available

The May ISMIE seminar "Medication Mishaps: Causes and Prevention" attracted 200 attendees in Chicago and more than 70 in Springfield. Audiotapes of the program are available from the Exchange for $33, plus $3.50 for shipping and handling. To order the three-cassette package, mail your payment to First Tape, Inc., 770 N. LaSalle St., Suite 301, Chicago, IL 60610. To order by phone, call (312) 642-7793, or fax your order to (312) 642-9624. ■

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Committees

(Continued from page 9)

that even the best physicians may face a claim sometime, the Physician Review and Evaluation Panel (PREP) provides medical expertise for the Exchange's underwriting process. As part of restructuring, PREP has been streamlined from three panels to one. This single panel includes physicians from all parts of the state, representing predominantly primary care and surgical specialties. Physician consultants for any specialty that is not represented on the panel are also available to help the panel make underwriting evaluations.

"The changes are intended to promote consistency and fairness, and ensure that all Exchange physicians are well-represented," said Dr. Clementi. "The component that makes the Exchange PREP special will not change: All PREP members are active, practicing physicians."

THE PROCEDURE PREP follows in reviewing a policyholder's case is not mysterious, Dr. Clementi noted. Each case closed with indemnity is referred to a committee member or consultant in the same specialty as the policyholder. Then, several weeks before the full PREP committee meets, that physician reviews the policyholder's entire insurance profile, not just the case in question.

"Doctors can be confident that decisions are made by their peers," Dr. Clementi said. "The physicians who serve on PREP are practicing Exchange policyholders. At one time, these physicians may have been in the same position as the doctors they are reviewing. They can empathize with their colleagues. This is what separates us from commercial insurers: They may have someone looking at the case from the physician's point of view, but the Exchange has peer physicians reviewing the cases for educational purposes in a committee forum."

NO ACTION is taken on most cases that PREP reviews. However, if the panel decides that some educational action is necessary, there are several possible options, including referring a physician for risk management training or CME, or assessing a surcharge. "There are strict principles the panel members follow when assessing surcharges. They are the exception, not the rule. They are used as educational tools and a way to stress the need for change in a physician's practice," said Phillip D. Boren,

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CLARITIN Tablets started working in some patients as soon as 30 minutes; 65% experienced relief within 2 hours.

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One 10 mg CLARITIN Tablet provides round-the-clock relief.

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In controlled clinical trials, the incidence of reported adverse effects in patients receiving CLARITIN Tablets was similar to that in patients receiving placebo. See CLARITIN Tablets full Prescribing Information.

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*In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

†Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03).

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Claritin®
10 mg TABLETS (loratadine)

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MD, past chairman of the ISMIS Board of Directors.

Dr. Boren stressed that less than 1 percent of Exchange policyholders have been assessed a surcharge. And when surcharges are levied, risk management or CME assistance is always made available to physicians, Dr. Boren said, adding that any recommendations stemming from reviews are educational in nature, not punitive.

"When physicians are sued, they are under tremendous stress," Dr. Boren continued. "They need to be protected and supported, and we are here for that purpose. But we never protect physicians at patients' expense. The panel's overall goals are to identify and address problems in a physician's practice. The service initiative changes will help make the Exchange's entire review process as uncomplicated and physician-friendly as possible."

"Involving physicians in the review process and educating them about risk management are at the heart of our company," Dr. Jensen said. "By implementing changes in these two critical physician committees, we move closer to our goal of providing the best possible service to our physicians." ■

Case in Point

(Continued from page 10)

• Document all contacts with your patients' subsequent treating physicians – even if those contacts occur before you are sued – so that the purpose of the communication is clearly connected with your medical treatment or follow-up care of patients. Never create the impression you are contacting another physician "to build your defense or ward off a lawsuit," said Glass.

• Be aware that the courts may, subject to plaintiffs' wishes, bar from testifying any subsequent treating physician who has been involved in ex parte communication, Smith warned. "If you contact a subsequent treating doctor [ex parte] whose testimony would be favorable to your case, you run the risk of never having that testimony presented to the jury," Glass added.

• Remember that plaintiffs' attorneys are allowed to contact subsequent treating physicians outside the presence of defense attorneys.

Although a bill was defeated this legislative session that would have allowed the communication currently barred by the *Petrillo* ruling, ISMS will continue trying to remedy the situation. ■

NEW

...A AND NON-NASAL SYMPTOMS
...F SEASONAL ALLERGIC RHINITIS

...KING NEW STRIDES
IN ANTIHISTAMINE
THERAPY

...MBURSABLE UNDER MEDICAID



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brand of loratadine

TABLETS
Long-Acting Antihistamine

BRIEF SUMMARY
(For full Prescribing Information, see package insert.)

INDICATIONS AND USAGE
CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS
CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS
General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: Drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, ketoconazole, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS
Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPDRTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBD-CONTRDLLED ALLERGIC RHINITIS CLINICAL TRIALS
PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing.
Body As A Whole Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.
Cardiovascular System Hypotension, hypertension, palpitations, syncope, tachycardia.
Central and Peripheral Nervous System Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.
Gastrointestinal System Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.
Musculoskeletal System Arthralgia, myalgia.
Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido, nervousness.
Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginitis.
Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.
Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.
Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema; abnormal hepatic function including jaundice, hepatitis, and hepatic necrosis; alopecia; seizures; breast enlargement; erythema multiforme.

OVERDOSAGE
Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdosage, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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EMERGENCY MEDICINE

Practicing medicine in the fast lane

From providing primary care to treating critically ill patients, ER physicians do a little of everything.

BY STACIE CROZIER



Matt Ferguson

When the emergency room's sliding doors open, you never know what will be waiting. There may be a patient with a sore throat. One or two with sharp abdominal pains. A couple of automobile accident victims. Someone having an asthma attack. Various cases of bumps, scrapes and sprains. Maybe someone with a violently inflicted wound and at least one case of chest pain.

Working in medicine's fast lane, emergency room physicians have honed their specialty over the years, adding more diagnostic tools, technology and triage to their traditional role as hospital "firefighters."

Stanley M. Zydlo Jr., MD, an emergency room physician for nearly a quarter of a century and a char-

ter member of the American College of Emergency Physicians, said his job has broadened since his days as a resident. "We [charter members of ACEP] were a diverse group – gynecologists, surgeons, internists, cardiologists who wanted to handle life-and-death emergencies – sort of Marcus Welbys-plus. But we've gone from total emergency care to more of an urgent-care role. Patients can hit us, spit on us, swear at us or vomit on us, and we've got to be nice. Customer service is part of our job."

Dr. Zydlo, chief of emergency services for Northwest Community Hospital in Arlington Heights, added that there is an ever-growing responsibility for ER doctors to handle cardiac patients, orthopedic patients and others who were considered "hands off" 25 years ago. "We see just about everyone with a life-threatening condition or serious injury before anyone else does, and we're now expected – by both doctors and patients – to be able to do things like start a heart attack victim on drugs to dissolve clots or order and interpret other high-tech tests. When I started out, cardiologists and orthopedists would never let us do more than the minimum until they got there."

An emergency room physician since 1978, Sam Gaines, MD, emergency department director for St. John's Hospital in Springfield, seconded that he and his colleagues "do a lot more diagnostic work now than ever before. And we need to be much more aggressive in dealing with cases such as cardiac patients."

This was always a nice Midwestern, Southern-Illinois town. You thought of gangs as being in big cities like Chicago, but we've really seen the incidence of gun and knife injuries go up here.

BESIDES GAINING a broader treatment range, emergency room physicians are also seeing more and sicker patients, as well as patients who come to the ER because they have nowhere else to go for medical care.

"The emergency room has become very much a place for primary care," said Dr. Gaines. "The patients we see have a lot more expectations of us and how we respond to them, because they're aware of what can be done for them. The ER fast track is getting more specialized, too. Patients receive triage for emergency care and urgent care, and that way everyone is seen faster."

Patients also increasingly perceive the ER as a convenience clinic, said Jacek B. Franaszek, MD, medical director of the emergency medical services department at Hinsdale Hospital. "The volume of patients who seek treatment in ERs across the nation has reached the 100-million-visits mark. We see the increase, in part, due to a growing number of indigents, but also because I think patients see us as the 'McDonald's' of medicine."

An ER physician since 1972, Dr. Franaszek said his basic mission hasn't changed much in the past 20 years. "We still look after everybody who comes in the door. It's still exciting, because you see all kinds of things every day, but it's a little more dangerous than it used to be." The dangers, he added, include an upswing in violence and the proliferation of infectious diseases that require strict adherence to universal precautions.

Dr. Gaines said those dangers have influenced the kind of cases his Springfield ER sees, as well as the way medical professionals respond to patients. "This was always a nice Midwestern, Southern-Illinois town. You thought of gangs as being in big cities like Chicago, but we've really seen the incidence of gun and knife injuries go up here.

"Ten years ago, all we worried about with regard to infectious disease was hepatitis," Dr. Gaines added. "Now with AIDS and the advent of universal precautions, we have to slap those gloves on before jumping in to save someone's life. We used to have the attitude that you just worried about the patient. Now we worry about our health and the welfare of our families, too."

As the pace of emergency medicine has zoomed into the 1990s, so have the pressures of the job, physicians admitted.

"Our jobs have evolved, just like medicine and technology have," said Ronnie W. Lee, MD, emergency medical services director at Loyola University Medical Center in Maywood. "There is a greater need to be more aware of different problems, because there are more and more critical patients to deal with – like renal and heart transplant patients, for instance. It is much more challenging today. You have to be diligent and up on things; you have to keep an ever-expanding knowledge base at your disposal."

THE KEY TO PREVENTING burnout is setting a manageable pace, said Dr. Lee. "You have to learn to pace yourself. I love the work. I like interacting with a variety of patients and diagnoses. I see a lot of different things every day, and that's what I enjoy about the job."

Dr. Gaines said he took a job at a smaller ER for a while, because it offered a slower pace and different administrative duties. "It was an interesting experience, but my family and I decided to come back to Springfield because the opportunities were better for us. After about 10 years, burnout can set in because you're getting older, and you tend to look more at what's happening within your family, not just with the job."

Dr. Franaszek said the attrition rate is higher for emergency room doctors than for other specialists. "They may have chosen what seemed to be a glitzy job that offers the luxury of going without beepers and getting lots of time off. But they begin to feel the effects of the night shifts and the long weekends, as well as family demands."

ER doctors may choose to decrease their hours and sacrifice a little income "so that they can enjoy the fruits of their labors," said Dr. Franaszek. "Some hospitals are responding by offering 8-hour shifts rather than 12- or 24-hour duties, having larger staffs and rotating doctors between emergency-care and urgent-care patients.

"Physicians can also choose to diversify by going into occupational medicine, toxicology, administration, sports medicine, pediatric emergency care or training paramedics," added Dr. Franaszek.

"The average [doctor] in this field lasts seven years," said Dr. Zydlo. "I've been here for 24. I love people, and I love making them as relaxed and comfortable as possible. There's always more to do in a day than you can do every day, but this is where all the action is." ■

AMA targets health system reform

AMA delegates adopt policy to help shape health care reform.

BY ANNA BROWN

At an annual meeting dominated by discussions of health care reform, the AMA House of Delegates took several steps to clarify and create its own reform policies. The House action during the June 12-17 meeting was in preparation for the unveiling of the Clinton administration's health care reform package, expected later this year.

The AMA Board of Trustees and several councils presented reports addressing health system reform. The board noted that its proposals were preliminary and subject to change; major revisions were anticipated. The board also acknowledged the AMA's input to the deliberations of the president's task force, but said it must withhold endorsement of the plan until review of a written draft of the proposal.

The AMA Council on Medical Service sought to include a broader range of services in the minimum benefits package included in the association's health reform proposal, Health Access America. The expanded benefits list was included in Report A. The House adopted the council report, calling the package the "type of protection that should be provided by employers and state risk pools." For example, the new package includes unlimited inpatient hospital days, unlimited physician office visits, extensive preventive services for children and adults, outpatient prescription drugs and hospice coverage. These benefits were either restricted or not included under previous versions.

In its "Health System Reform Update," the board discussed several features of the proposed Clinton plan that seem to conform to AMA policy. These include employer mandates with appropriate financial assistance for small businesses; a standard benefit package; elimination of pre-existing condition provisions; pluralistic delivery mechanisms with fee-for-service, HMO and PPO options; patient and physician freedom of choice; antitrust relief; and some degree of professional liability reform.

The report also addressed financing, noting the AMA's opposition to a federally established employer payroll premium, because it would "place the government in control of financing the entire health care system." The AMA also opposes strict global budgets.

The board said the AMA will support only those components of a national plan that complement Health Access America.

The House also adopted the recommendations of a board report detailing fundamental aspects of health system reform, such as antitrust relief. The "Negotiations Issue Status Report" advocated promoting physician organization involvement in health policy decisions, and supporting and enhancing the self-regulatory structure of the medical profession.

The delegates also reaffirmed policy supporting continuation of activities to reform Medicare. Prompted by lengthy testimony, the reference committee added a recommendation to "support a blend of private and public responsibilities" for health care delivery.

The House also acted on a Council on Medical Service report addressing employer-based health insurance. The council recommended that the AMA continue to examine an individual-based insurance option under any health system reform plan. In addition, it offered several payment options that could be incorporated into individual-based or employer-based systems. These options include accountable health plans and health savings accounts to "encourage individuals to purchase lower-cost, higher deductible coverage."

The House of Delegates referred back to the board a report attempting to clarify AMA policy on explicit rationing of health care. After considerable testimony, the reference committee concluded the issue requires further study.

A number of resolutions affecting health system reform were adopted. The House approved resolutions reaffirming policy to increase federal excise taxes for tobacco and alcohol, and to allocate those tax dollars to fund health care and health education. The delegates also amended AMA policy to establish a tax increase on all tobacco products. A portion of these monies would be used to educate the public about the danger of tobacco and to help fund health care for the uninsured. In addition, the House reaffirmed policy calling for the elimination of tobacco subsidies. The Illinois delegation supported these measures. ■

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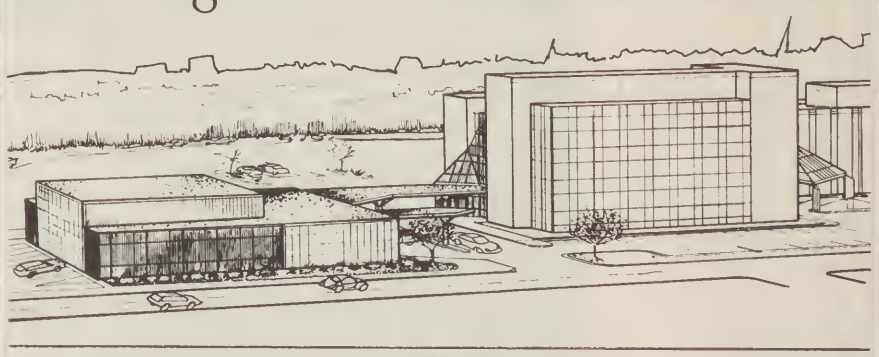
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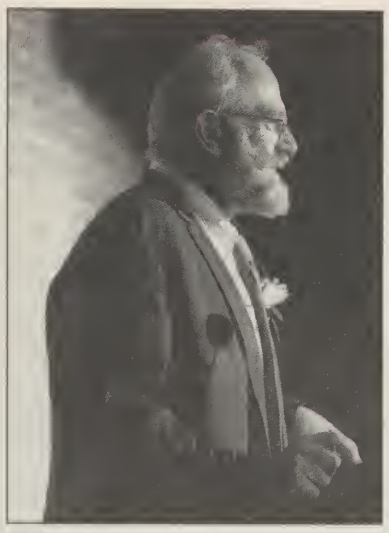
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Author of *Awakenings* speaks at Rockford conference

The physician who tested L-dopa on 'sleeping volcanoes' – patients suffering from encephalitis lethargica – shares some of his experiences. By Kevin Kelleghan

When I was a medical student, I had no idea there were tens of thousands of people still catatonic in state hospitals, insane asylums and nursing homes," said the author of the best-selling book *Awakenings*. Oliver Wolf Sacks, MD, addressed 400 physicians gathered for the 54th Annual Theodor Lang May Day Clinic, sponsored by St. Anthony Medical Center in Rockford. "These were forgotten people in a strange standstill. They asked me to tell their story, and in talking to you, writing the book *Awakenings* [and through] the film – I am honoring this commitment."

DR. SACKS WROTE his account of the dramatic effects of the L-dopa drug he administered in 1968 to postencephalitic parkinsonian survivors of the sleeping sickness epidemic of 1919-27. That book was the subject of a British television documentary and the inspiration for a one-act Harold Pinter play. It was dramatized in the 1990 film *Awakenings*, with Robin Williams playing the role of neurologist Dr. Oliver Sacks.



David Friedrich

Dr. Sacks

Dr. Sacks studied physiology at Queen's College, Oxford, earned his medical degree from Middlesex Hospital and relocated to the United States in 1960.

"When I went to New York in 1965, I tried to be a real scientist," Dr. Sacks said. "But I didn't spend five years with earthworms, as the movie implied. I spent only one year."

He then joined a chronic care hospital in the Bronx, Beth Abraham Hospital, where he was astonished to learn "some patients had been [in the hospital] 40 to 50 years."

"I found people transfixed – sitting, standing, in bed – completely motionless. The illness presented itself in different ways: tics, somnambulance. Many had symptoms of Parkinson's disease. No cure was ever found."

THE ENCEPHALITIS lethargica epidemic had affected 3 million to 5 million people worldwide. About a third of them died. Some recovered, but died later. Back in 1966, there was no medical or surgical treatment for the illness. Parkinson's medicines were not useful for this akinetic state.

Then, in 1967, L-dopa arrived. "It was a wonder drug," said Dr. Sacks. He compared its reception to the perception of cortisone as a miracle drug in the 1940s.

The patients had been described as extinct volcanoes, "but I felt they were sleeping volcanoes," Dr. Sacks said. "I delayed giving them L-dopa. I wondered what would happen after [their] being out of the world for 40 years. But in 1968, a heat wave made the illness life-threatening."

As a result of his tests with L-dopa, some patients "awakened," becoming extremely alert. Eighty patients awakened over a period of two months – one within seconds. "Mrs. Y" talked to people. "She wanted a steak instead of the thin soup she usually got," Dr. Sacks recalled.

Mrs. Y later wrote in her journal, "I feel very good. I would like to express my feelings, but I have no words. I wish I had a dictionary to use – I haven't spoken in years."

"A patient who hadn't moved for years would get up and walk across the room," said Dr. Sacks. "These occasional awakenings showed there were people inside."

Another patient awoke after 40 years to write, sing and dance. Dr. Sacks showed film footage of some of these awakenings to the Rockford audience.

Dr. Sacks explained that patients zoomed from youth to old age with no transition. One patient said, "I know I'm 64, but I feel 21. I've been a spectator for 40 years."

At the time, Dr. Sacks wondered, Will this last? Problems arose. "They could not hold the effect physiologically. There is only one correct dosage of any medicine: enough. We didn't know then what was 'enoughness.'"

Several patients experienced respiratory illnesses. Another went from extreme states – hyperactive to frozen – with no intermediate state.

By 1972, Dr. Sacks was trying all sorts of drug combinations. The condition of one patient, a cobbler, improved greatly when he could work at a shoemaker's last, supplied to him in the hospital. "Health is not just the drug but the fullness of life," Dr. Sacks noted. "I found music was very important to them," he added.

Dr. Sacks, who was described as "one of the great clinical writers of the 20th century" by the *New York Times Book Review*, continues clinical work at Beth Abraham Hospital. He is also professor of neurology at Albert Einstein College of Medicine, New York, and is writing his sixth book.

In another address at the conference, Dr. Sacks appealed to physicians to create a clinical story with patients because "they don't have the words to communicate. My patients in *Awakenings* were like this. When I had a neuromuscular injury, I lost the sense that it was my leg. It was like a spinal anesthetic. But I couldn't communicate this."

He urged his audience to consider that the "patient and the doctor each teach and learn from the other. The first thing one has to do as a doctor is to listen and to attend. We don't have any language for pain. The patient has the experience and tries to tell it. We try to make sense of what he's trying to tell us and return this to him.

"Listening [to], making and telling the story is where medicine started," Dr. Sacks concluded. "And I think [the story] will always remain a part of medicine." ■



Doug Lawhead

MARSHALL FAMILY PHYSICIAN James A. Turner, DO (right), leads U.S. Sen. Paul Simon (D-IL) on a tour of the Cork Medical Center on July 7. In addition to touring the medical center's facilities, Simon met with members of the medical staff. Dr. Turner presented Simon with a Marshall High School t-shirt and hat as souvenirs of his trip to the city. Later that day, the senator held a town hall meeting for area residents to voice their opinions about health care reform.



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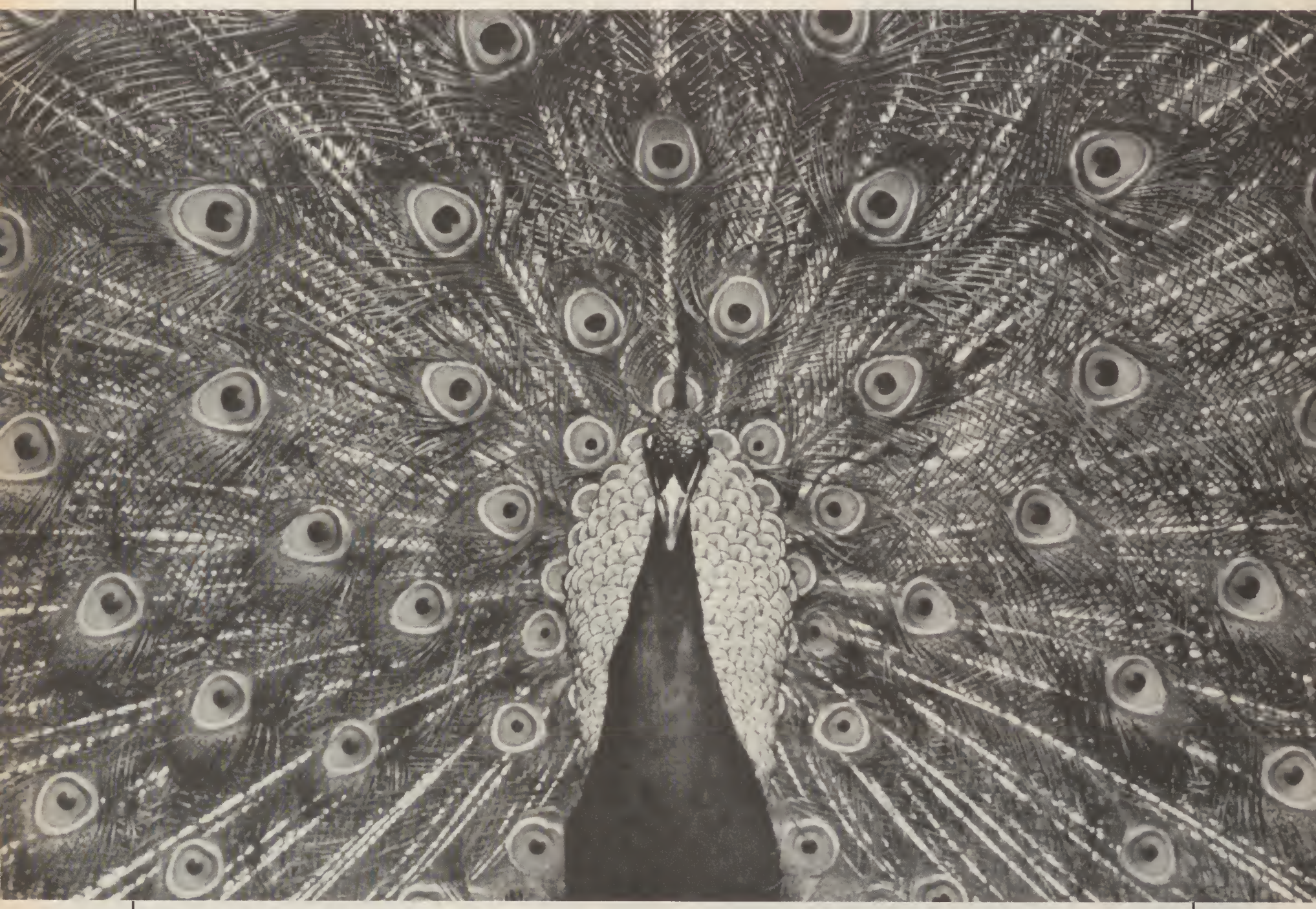
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Floodwaters

(Continued from page 1)

cy Management Service spokesperson. Flooding is being blamed for more than 20 deaths in other states, but to date there have been no reports of flood-related deaths in Illinois, he said.

"Our job is to coordinate the efforts of all state agencies involved in the response to, and recovery from, the floods," Quigley said. "But our No. 1 priority is responding to human needs. Then we fight the flood, and then we work toward recovery."

Illinois' county health departments are responding to the disaster by alerting residents to potential health hazards caused by standing water, according to the Illinois Department of Public Health. People living in affected areas should try to avoid contact with floodwater because it may contain bacteria, viruses and other infectious organisms, said IDPH Director John R. Lumpkin, MD.

Health department officials from across the state are recommending that people in flooded areas check to make sure their tetanus shots are up-to-date; shots are advised for people who have not been inoculated within the past 10 years. Residents are also cautioned to protect broken skin areas where tetanus bacteria typically enter the body.

With the exception of unopened, undamaged canned goods, food items that have come in contact with contaminated water should be discarded. Dr. Lumpkin said canned foods may be safely consumed if the cans are rinsed well with a solution of one-fourth cup bleach per gallon of water and then dried before opening. Eating infected food can lead to gastrointestinal disorders with symptoms including nausea, vomiting, diarrhea, abdominal cramps, muscle aches and fever. Individuals suffering these symptoms should immediately seek medical attention, Dr. Lumpkin stressed.

Virginia Scott, administrator for the Jackson County Health Department, said the Carbondale area is beginning to experience pockets of serious high water. On July 18, Jackson County was declared a federal disaster area. Phone calls asking the department for advice are increasing daily, she said. "People want to know if it is safe for children to play in the water, if it is safe to drink their water. So far we have sent news releases to the local media warning people of the dangers, and we have distributed informational fliers throughout the community. As the situation changes, I'm sure we will be receiving requests to test private water systems and see an increase in the number of people seeking immunizations."

In the meantime, the Jackson County Health Department is concentrating on providing information to area residents about keeping children and pets away from floodwater and wildlife, which may be infected with rabies.

IN ADAMS COUNTY, one of the 24 Illinois counties eligible for federal disaster aid, the local health department is focusing on inoculating residents for tetanus. "When people start moving back into their homes, we will provide information to ensure they take precautions before using water or food that has been in contact with floodwater," said a health department spokesperson. If residents in Quincy and other towns in the county are unsure whether their water supply is uncontaminated, they should use only bottled water or tap water that has been boiled and appropriately disinfected, according to the health department.

When the water levels recede and people are able to return to their homes and offices, flood victims should pay particular attention to structural, electrical and gas-leak hazards, IDPH warned. Battery-powered flashlights should be used when examining dwellings, because oil or gas lanterns and torches could ignite flammables, Dr. Lumpkin said. Also, electrical equipment should be checked and dried before returning to service.

Individuals interested in volunteering may contact the state's flood relief hotline at (800) 650-CARE. ■



Ian Solender

Relief workers throughout the state are receiving vaccinations to prevent tetanus and hepatitis A from contact with polluted floodwater. Claudette Klimes, RN (right), head of the Illini Occupational Health Services, gives tetanus shots to employees of the Spectrum Data One company in Moline. Earlier this month, company employees volunteered to try to fight back the overflowing Mississippi River.



PRESIDENT CLINTON designated 24 Illinois counties as federal disaster areas, making them eligible for federal emergency disaster loans. The counties are Adams, Alexander, Boone, Calhoun, Carroll, Hancock, Henderson, Henry, Jackson, Jersey, Jo-Daviess, Lake, Madison, McHenry, Mercer, Monroe, Pike, Randolph, Rock Island, St. Clair, Stephenson, Union, Whiteside and Winnebago.

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MEMBERS IN THE NEWS

After extensive work by its physician search committee, the town of Hoffman welcomed family physician **Elizabeth A. Wuebbels, MD,** of Carlyle, to the city's new clinic. Dr. Wuebbels sees patients on Tuesdays and Thursdays at the clinic, which opened in May. Dr. Wuebbels is also a member of the medical staff at St. Joseph's Hospital in Breese and is in private practice in Carlyle.

Neil J. Stone, MD, a cardiologist practicing in Chicago, has received the first Northwestern Memorial Hospital Jacques M. Smith, MD, Distinguished Physician in Medicine award. Dr. Stone was recognized for his caring attitude toward patients, which combines "the highest degree of technical attainment in the practice of his specialty, with a sensitivity to the needs of each patient."

"'Distinguished physician' is the highest honor the hospital can bestow on a member of its medical staff," said Gary A. Mecklenburg, president and CEO of Northwestern. "As the first Smith distinguished physician, Neil Stone will make important contributions to patient care and academic programs in cardiology at Northwestern Memorial."

Established with a $500,000 endowment, the appointment honors the memory of Jacques M. Smith, MD, a cardiologist whose 45 years of medical practice were dedicated to compassionate and progressive patient care. It provides the recipient needed financial support to conduct research and studies that contribute to enhanced patient care. Dr. Stone is expected to use the endowment to continue cholesterol research and lipid studies.

The Illinois Department on Aging recently joined the American Association of Retired Persons in recognizing individuals, businesses and community organizations for their outstanding contributions to providing care to the elderly. **Maude A. Sanders, MD,** of Peoria, received the Governor's Award for Unique Achievement. Dr. Sanders retired in 1990, after being in general practice for 48 years. During her years in active practice, she was often described as her patients' "mother, sister, friend, lawyer and counselor." The awards were presented at the governor's mansion in Springfield during a May reception celebrating Older Americans Month. ■

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Study shows interpreter training still needed

BILINGUAL STAFF: Hospitals are hiring more interpreters to help health care providers communicate with non-English-speaking patients. By Anna Brown

[CHICAGO] Results of a new study show that hospitals and clinics hire bilingual staff members to serve as interpreters but "fail to adopt adequate measures to assure quality and competency." Conducted by the Immigrant and Refugee Health Task Force of the Travelers and Immigrants Aid of Chicago, the study surveyed 47 Chicago-area health care facilities.

All of the hospitals responding to the survey and 17 of the 20 responding clinics said they use ad hoc interpreters, such as support staff who act as volunteer interpreters when needed. Most institutions said they planned to hire more bilingual staff.

The survey confirmed suspicions about hospital interpreter shortages and use of untrained interpreters, said Wendy Siegel, task force chairman. The study also found that health care forms and documents printed in Spanish are becoming more common in Chicago-area hospitals and clinics. Translations into other languages, however, are still rare. Most significantly, respondents reported that patients with poor English skills typically experience such problems as "delayed care, inability to follow medication directions and difficult diagnosis," according to the study.

The study concluded that "providers of health care will have to change their current policies and practices if they wish to better serve the needs of our newest immigrants."

BY HELPING introduce legislation this year, Travelers and Immigrants Aid attempted to eliminate inadequacies in health care delivery for patients who do not speak English or whose English is limited. S.B. 435 would create the Language Assistance Services Act, requiring hospitals and nursing homes to develop policies for providing interpreter services. Introduced by Sen. Jesus Garcia (D-Chicago), the bill passed the Illinois General Assembly and awaits Gov. Jim Edgar's signature.

The bill is expected to reduce language barriers that can obstruct health care services. Under the legislation, health care facilities would review and revise existing policies on language assistance, develop community contact groups to oversee interpreter services, and record patients' primary language on medical charts, hospital bracelets, bedside notices and nursing cards, to provide "adequate communication between patients and staff and minimize delays in treatment." Health facilities would be required to comply with the legislation if at least 5 percent of their patients did not speak English, spoke limited English or were deaf. ■

Pottery source of lead poisoning

SCREENINGS: Public health officials are intervening to try to limit lead exposure in the Hispanic community. By Anna Brown

[ARLINGTON HEIGHTS] The Cook County Department of Public Health has identified some South American pottery as a possible source of lead poisoning among children in suburban Cook County. To address this and other lead-poisoning-related problems, the department co-sponsored a June 29 health fair with the Village of Arlington Heights in a neighborhood apartment building in which 80 percent of the residents are Hispanic. Health care workers completed lead screenings on 25 medically indigent Hispanic children and pregnant women living in the building.

HEALTH DEPARTMENT STAFF said they believe pottery is a source of many lead poisonings, especially among Hispanics who use pottery to cook, store and serve food. "We need to let the community know that they should not be using imported pottery for food," said Jo Rose, CCDPH director of community health. "The pottery, paint and finishing glaze may contain lead. It is difficult to determine at what point in the production of the pottery that lead was used, if at all. We are recommending that people who use South American pottery use it only for decoration and immediately start using glass, stainless steel or plastic containers for food."

"When you go into homes for environmental inspections, you see the pottery sitting on the stove," said Jo Ellen Maxheimer, a department environmental health impact nurse. "We see people eating right out of [the pottery]. People tell us that the food tastes better. We tell them to use Corning Ware and hang the pottery on the wall."

Maxheimer noted that all pottery, whether painted or not, is a potential source of lead poisoning when used for cooking. She said the department targeted its education effort at the Hispanic community because of its heavy use of pottery. "People are using grandma's dishes, or they can buy them at the corner store," she said.

Area residents were encouraged to bring their pottery to the fair if they were concerned about possible lead content. At the fair the department displayed examples of pottery with high lead levels. ■

Urban health care

(Continued from page 1)

acknowledged that communicable diseases "are here to stay" and focused on health departments' roles in disease control and surveillance. The health officials also considered ways to improve feedback to the community, enhance evaluation and use of data, and overcome compliance barriers. "We'll have to do better, because we'll always have a job," Dr. Wilhelm said.

Chicago Board of Health President Whitney W. Addington, MD, delivered the keynote speech for the health promotion and chronic disease prevention track. He discussed alternative health care delivery methods for reaching minorities and populations that are especially affected by tuberculosis and AIDS. "As TB levels fell in the 1970s and '80s, our guard was down, and funding became nonexistent," he said, noting that this is part of the reason for the current TB and inner city health crisis. "The demographics of populations can predict the spread of every disease except HIV. Even that is shifting to minorities, especially poor minorities.

"The United States spends much more on health care than any other country, and yet infant mortality is higher than in some Third World countries. Measles, HIV, TB and asthma deaths are out of control," he continued. "Some issues must be addressed, or we won't make any progress."

Solutions to these problems are often nonmedical, Dr. Addington said, praising "directly observed therapy" for TB, a process by which health officials actually monitor patients taking their medication. He also suggested implementing educational programs to teach IV drug users how to treat and use needles properly. To control TB in jails, Dr. Addington said x-ray screening should be used instead of skin tests, which often cannot be checked.

THE INJURY CONTROL and prevention track included panel discussions and lectures addressing community-based injury and violence control. Chris Kosmos, CDOH director of injury and trauma control, said the programs stressed that health officials should make direct contact with communities. She cited the example of a Milwaukee health department director who walks through city neighborhoods and teaches on-the-spot violence-mediation techniques to residents.

Food-borne illnesses and lead poisoning were among the topics covered in the environmental health track. Specifically, participants discussed food and dairy protection, solid waste management, vectors and urban entomology, water quality, abandoned housing and lead contamination, said CDOH chief sanitarian Ken Pannaralla. "Good public health includes preventive actions. These are so easily done, but we've got to have money." ■

HHS chief

(Continued from page 1)

"Proper economic incentives" will be developed and implemented to make primary care more attractive, such as helping health professionals repay their student loans if they choose primary care careers, Shalala said.

Shalala told the audience that public health leaders will be "where the action is" in redesigning the health care system's infrastructure. "You can expect to see strengthened community-based clinics and outreach programs, a decentralized delivery system, a benefit package that emphasizes prevention and a structure that encourages competition but allows the states to determine the extent.

"Americans want peace of mind," she continued. "They want a commitment [from government] that their health care system will always be there for them. People want something that builds on the private system, and competition is the key to assuring a system of low-cost, high-quality care." ■

Joint Commission to evaluate networks

[OAKBROOK TERRACE] The Joint Commission on Accreditation of Healthcare Organizations has announced plans to begin evaluating health care delivery networks by January 1994. Proposed reform initiatives at the federal and state levels indicate that health system reform will likely include networks of practitioners and provider entities, said Dennis S. O'Leary, JCAHO president.

"Accountability for cost and quality are key ingredients of most reform models. It is clear that the emerging new accreditation model will be readily adaptable to a variety of individual health care provider entities and to more complex systems of care," he said.

The JCAHO also announced plans this summer to resume accreditation of hospice services. The JCAHO hospice accreditation program was started in 1984, but was consolidated into other accreditation programs in 1990. JCAHO consolidated the hospice evaluations as part of an ongoing effort to incorporate standards of care for dying patients into all of its accreditation programs. But since 1990, hospice services have expanded, and O'Leary said the commission recognizes the need to evaluate the special characteristics of patient care provided in hospice settings. ■

Medicare

(Continued from page 1)

when they know clearly that what they are doing is not appropriate," he said, citing as an example physicians who are paid to fill out forms for DME companies so that patients can receive equipment or services that are not medically necessary. But sometimes physicians are misled by companies and patients, he said, which could cause physicians to unknowingly abuse the Medicare system.

The carrier considers program abuses to include excessive billing for services or levels of care that a physician has not documented or deemed necessary, according to ISMS advisers.

"Medicare is as forgiving as possible," Dr. Schneider said, adding that many physicians have expressed concern that they will be held as accountable for committing alleged abuse as they would be if they defrauded the system. He said he hopes that Medicare will start with an effort to educate physicians about abuses before they occur.

PHYSICIANS ALSO MUST LEARN to recognize possible signs of a sophisticated scam, according to a Blue Cross spokesperson. In addition, doctors may need to be more aware of the reasons and necessity for ordering medical equipment and tests for their patients, ISMS advisers said.

A recent Blue Cross alert detailed a scheme involving a large interstate clinical laboratory that agreed to pay more than $110 million in damages to Medicare and Medicaid for submitting false claims. According to the alert, the scheme caused several physicians to order unnecessary services. The laboratory did not inform physicians that it was billing insurers for HDL-cholesterol tests when they ordered Sequential Multi-Analysis Computer (SMAC) tests. The laboratory performed the extra test and billed the physician a nominal amount. The charge was dropped for physicians who objected, and new physicians were told that the test was free. The laboratory revised its order form by calling the SMAC test a "health survey profile," which also included the HDL-cholesterol test and a serum ferritin test, but the lab failed to inform physicians about what the profile included, Blue Cross said. The lab billed Medicare $16 for each additional test.

"Physicians must look at lab results closely because labs may be running tests that doctors don't order," said Dennis Cullerton, a Blue Cross spokesperson. "Take a look at the entire results that could increase the bill," he advised, noting that physicians usually don't see the bills submitted to Medicare. "This is a very sensitive area for physicians. But if they try to do as much homework as they can, they won't have to be nervous."

THROUGH THE TPPP Committee, ISMS has encouraged the carrier to carefully distinguish between program abuse and procedural billing errors so that physicians who submit a claim with an inadvertent procedural code error are not accused of fraud. ISMS has stressed that incorrect claim completion and simple coding errors should not be considered as serious as fraud and abuse.

"Doctors are at particular risk of being [scrutinized for potential] fraud and abuse when they sign forms without reading them," Dr. Schneider cautioned. "Don't just blindly sign anything that comes across your desk, because you will be held responsible."

Physicians who experience difficulties with carrier review programs may contact the ISMS department of economics at (312) 782-1654 or (800) 782-ISMS. ■

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New budget boosts state employees' health plan

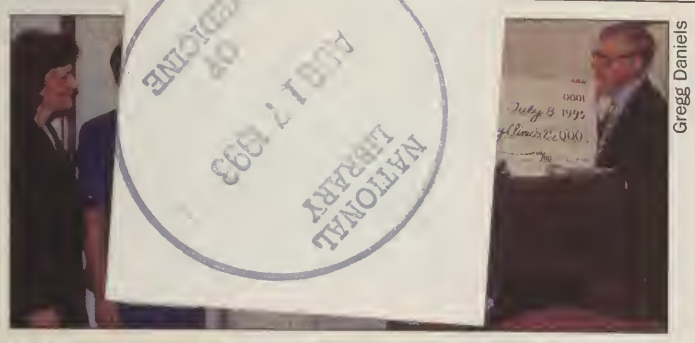
PAGE 3



ISMS-Alliance mini-internship program

PAGE 15

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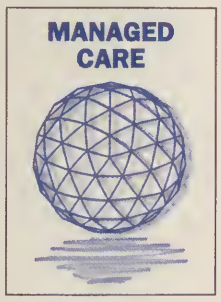
Gregg Daniels

MEMORIAL MEDICAL CENTER presents a check for $25,000 to HealthFirst Community Clinic organizers (from left) Kathy Pearson, Jane L. Jackman, MD, and Virginia M. Dolan, MD, at a press conference July 8. The clinic will open in early 1994. See story page 4.

Preparing for reform tops doctor-hospital seminar agenda

MANAGED CARE: Illinois physician and hospital leaders explore ways to collaborate. By Gina Kimmey

[OAK BROOK] Improving the level of trust between physicians and hospitals was the overriding theme of a seminar for physicians and hospital officials held July 22 in Oak Brook. Sponsored by ISMS, IHA and the Chicago Medical Society, "Physician/Hospital Collaboration in an Era of Health Care Reform," examined integration of medical staffs and hospitals, and the practical aspects of making these relationships work.



"Today makes me feel very optimistic; we're taking a big step forward to open the lines of communication," ISMS President Arthur R. Traugott, MD, told attendees. During his remarks, Dr. Traugott thanked ISMS Third District Trustee Dennis M. Brown, MD, who spearheaded ISMS involvement in the seminar. Dr. Brown is ISMS' liaison to IHA's Council on Medical Staff Affairs.

The program was significant because it combined the resources of physicians and hospitals, Dr. Brown said.

(Continued on page 22)

INSIDE

Dr. Mitchell honored by family physicians' group

PAGE 3



DuPage medical society foundation aids needy students

PAGE 5

Physician convicted for diverting Schedule II drugs

PAGE 2

DEPARTMENTS

News Briefs.....2

Illinois Watch 4

Commentary.....6

ISMIE Update 9

Classifieds 17

Poison control loses to cost control

CRISIS: With no public funding to fall back on, one of Illinois' three poison control centers is closing. By Gina Kimmey

[SPRINGFIELD] St. John's Poison Control Center in Springfield, one of only three such centers remaining in the state, will cease operating Sept. 1. The St. John's Hospital board of directors voted July 28 to close the center because of cost considerations, according to a hospital spokesperson. Through its absence, the southern half of Illinois will be one of the largest regions in the country not covered by a poison control center. The state's remaining centers are in Rockford and Chicago.

"At an annual cost of $340,000, the center's expenses have stretched beyond the means of the hospital's operating budget," said Aggie Haynes, St. John's director of community relations. "The 800 number alone costs $850 per month, and the Poisindex costs $14,000 per year." Of the 80 hospitals in the region, only 24 others have Poisindex, a continuously updated system with information about toxic substances. St. John's will maintain the Poisindex for its own use, Hayner said.

Serving 62 counties and 2.3 million people, the center receives more than 30,000 calls per year. Without the St. John's center, all of those calls will have to be rerouted, according to the Illinois Department of Public Health. "The IDPH will look for other hospitals in the

(Continued on page 20)

Thousands volunteer for flood relief efforts

DISASTER: Illinoisans extend a helping hand to those devastated by this summer's flooding. By Gina Kimmey

[SPRINGFIELD] Confronting the worst flood in the state's history, Gov. Jim Edgar July 19 thanked the thousands of volunteers who have helped shore up levees and aid victims facing the loss of their homes and businesses.

"Not surprisingly, one of the worst natural disasters to hit Illinois has brought out the best in Illinoisans," Edgar said. "Those who have valiantly battled the flooding in order to protect their homes and livelihoods have been joined by thousands upon thousands of volunteers in an unprecedented outpouring of assistance. More than 9,000 volunteers participated in sandbagging [in July] after calls to our hot line."

One of those volunteers was Springfield internist Jane L. Jackman, MD, president of the Sangamon County Medical Society. Inspired by a patient

(Continued on page 23)

ISMS BEHIND THE SCENES

HEALTHY MOMS/HEALTHY KIDS: QUESTIONS AND ANSWERS

The Illinois Department of Public Aid's Healthy Moms/Healthy Kids program, like any new program, has hit its share of bumps in the road. "We want physicians and patients enrolled in the program to be satisfied and comfortable with its operations, so occasionally participants will need some clarification about how it works," said ISMS President Arthur R. Traugott, MD.

The Society's board of trustees endorsed the program in April, and Dr. Traugott said although ISMS supported the goals of HMHK, many physician leaders expressed concern about some operational details. One of those concerns involved the patient enrollment process. Even though HMHK is a managed care program, Medicaid recipients may continue seeing their personal physician, provided that their doctor participates in the program.

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Physician convicted for diverting Schedule II drugs

TRIP SCRIPTS: Despite a recent investigation resulting in a physician conviction, physician arrests are rare. By Anna Brown

[OAK PARK] An Oak Park physician who diverted $17 million worth of Schedule II prescription drugs was convicted June 2 after a joint investigation by the Illinois Department of Alcohol and Substance Abuse and the federal Drug Enforcement Administration. Juliet S. Dumlao, MD, and 16 other defendants pleaded guilty to scheming to obtain and sell thousands of tablets of Dilaudid, a prescription drug sometimes referred to as "drugstore heroin." According to DASA, each tablet is worth as much as $40 on the street – about four times its pharmacy cost.

DASA's Triplicate Prescription Control Program pointed investigators to Dr. Dumlao and several of her patients, said Ron Vlasaty, administrator of DASA's division of regulatory and support services. The physician triggered an investigation when DASA records showed she was prescribing more Dilaudid than any other physician in the state.

Dr. Dumlao was unavailable for comment.

"It was very clear that we had identified about a dozen professional patients through the [triplicate prescription] program," Vlasaty said. "Without prescriptions as proof, the only way to find out if the system is being abused is through complaints."

The physician's conviction ended the biggest illegal drug diversion case the department has investigated, Vlasaty said. Physicians are rarely found to be dealing in illegal drugs, he said, adding that the program more often uncovers "professional patients" – individuals who attempt to gain prescriptions for narcotics by visiting several doctors' offices. The department's computer system can track the number of prescriptions written for one patient, Vlasaty said.

"We haven't seen any figures that show that physicians are largely responsible for illegally trafficking Schedule II drugs," said Fred Z. White, MD, a family physician who until recently was a member of DASA's Drug and Substance Abuse Committee. "Professional patients are primarily at fault, but there are very few patients and doctors who divert drugs. The triplicate prescription program does prevent careless prescribing."

Physicians prescribe Schedule II controlled substances on numbered forms registered to them by the department. One copy of the triplicate form is kept in the physician's records; another copy is kept at the pharmacy that filled the prescription; and the third is sent to DASA. The department assumed responsibility for the program in 1984. Since then, there has been a 90-percent reduction in fraudulent use of triplicate forms and a dramatic reduction in the illegal prescribing of Dilaudid and Preludin, the most commonly abused Schedule II drugs, according to DASA.

"When they are misused, prescription drugs can be as dangerous as illegal drugs," said DASA Director Jim Long. "I hope these convictions send a message that those who illegally divert prescription drugs will be caught and brought to justice."

Fourteen other states currently have triplicate programs. ■

Death cigarettes: Truth in advertising

[VENICE, CALIF.] On the market for about 2½ years, Death cigarettes are a hit in England and Japan, and are now attracting a following in the U.S., particularly in California. The black cigarette package with its skull-and-crossbones logo goes well with the company's ad slogan: "Don't smoke Death cigarettes." According to Charles Southwood, head of Death Tobacco in America, the company's goal is "to sell our product and get the message out that cigarettes kill."

"When people see the package, they get the message," Southwood said. Accompanying the surgeon general's warning on each package is the message: "Cigarettes are addictive and debilitating. If you don't smoke, don't start. If you smoke, quit."

The company recently encountered difficulty selling the cigarettes in this country. The trademark black package with the skull logo was first used by Black Death Vodka, a product that hit the market just four months before Death cigarettes. The vodka maker failed to register the trademark, said Southwood, but a federal judge prohibited further distribution of Death cigarettes in the United States. Southwood said the company will appeal and hopes to be selling the cigarettes again soon. ■

IDPH takes aim at mosquitoes

[SPRINGFIELD] Addressing the onslaught of summer insects, the Illinois Department of Public Health has awarded $157,000 in grants to help 18 local health departments and a municipality control container-breeding mosquitoes.

"The grants will help track and control the mosquito population and, in turn, protect the health of our citizens by reducing the probability of mosquito-borne diseases," said John R. Lumpkin, MD, state health director.

Community need was based on the presence of Asian tiger mosquitoes, used-tire sites (where mosquitoes breed), past cases of mosquito-borne encephalitis, geographic region and population size, IDPH said. In addition, the Mercer County Health Department received a $500 grant for surveillance and control of Lyme disease and deer ticks.

Although severe mosquito problems are anticipated from the flooding along the Mississippi River, IDPH is currently working with the U.S Centers for Disease Control and Prevention to measure the mosquito population in those areas. Those efforts will be paid for with separate funding, the department said. ■

Help Me Grow program continues

[SPRINGFIELD] Illinois first lady Brenda Edgar last month announced that her Help Me Grow campaign for children is entering its second phase with a new focus on the importance of prenatal care. Public service announcements about prenatal care are running on television and radio stations throughout the state.

"A baby's future is dependent on the care his or her mother receives and how she treats herself during pregnancy," Edgar said. "The Help Me Grow public service announcements will give pregnant women access to information about the need for regular medical check-ups, especially for those expectant mothers who cannot afford or do not know how to obtain prenatal care."

Launched in April, the Help Me Grow program is a public-private partnership sponsored by the Ronald McDonald Children's Charities and 12 Illinois state agencies. The public awareness campaign provides information to parents and guardians about preventive services for children and families.

Approximately 18,000 pregnant women failed to obtain prenatal care in Illinois last year, Edgar said, adding that 15,200 babies were born with problems ranging from drug toxicity to birth defects such as mental retardation and cleft palates. The state currently spends more than $75 million a year on education and treatment programs for pregnant women and children, she said.

To complement the Help Me Grow program, the Illinois Department of Public Health developed *The Healthy Baby Book*, detailing appropriate medical care for pregnant women and newborns. The state is offering the book and help for pregnant women to locate a physician and other prenatal services through its Help Me Grow hot line, (800) 323-GROW. ■

PHYSICIAN FACTS

The price of childhood immunization

Private

	1982	1990	1992
DTP	$ 1.85	$53.25	$50.20
OPV	$11.00	$38.96	$39.64
MMR	$10.44*	$48.14	$50.58
HIB	–	$14.55	$60.52**
Total	$23.29	$154.90	$200.94

Public

	1982	1990	1992
DTP	$ .75	$34.57	$29.93
OPV	$1.90	$ 7.68	$ 8.38
MMR	$4.02*	$29.43	$30.66
HIB	–	$ 5.20	$21.46**
Total	$6.67	$76.88	$90.43

* Second dose of MMR not recommended
** Based on four doses of HIB
Source: Centers for Disease Control and Prevention, 1993

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This is the first in a series of articles detailing how physicians will be affected by the state's fiscal 1994 budget.

New budget boosts state employees' health plan

EMPLOYEES: Increased funding for the state employees' health plan may expedite historically slow physician reimbursement.
By Gina Kimmey

[SPRINGFIELD] Although the General Assembly chose not to adopt Gov. Jim Edgar's proposal to fully fund the state employees' health plan, it did appropriate $65 million in newly budgeted funds for the program. General revenues for the plan will increase to $429.9 million for fiscal 1994, up from $365.5 million last year, according to Helen Adorjan, spokesperson for the Department of Central Management Services, the state agency that administers the health plan.



"With the increased funding, we expect to see improvements this year," said Adorjan. "The delays won't go away, but the situation will improve. Ideally, PPO hospitals should receive payment in 30 days, and all other providers, including physicians, should be reimbursed within 60 days."

Last year, the General Assembly had to approve nearly $40 million in supplemental funds to help keep the plan afloat financially through the year, Adorjan said.

The slow reimbursement situation is not as bad as it has been in the past, according to Jane L. Jackman, MD, Sangamon County Medical Society president. "Of course we wish the General Assembly had approved fully funding the program, but we welcome any increased funding," she added.

About 30 percent of the patients in a Sangamon County physician's practice are state employees, said Dr. Jackman. The delay in reimbursement can have a tremendous economic impact. "Ever since the state decided to self-insure, the program has been underfunded. You

(Continued on page 22)

Dr. Mitchell honored by family physicians' group

DEDICATION: Heralded as a role model, Dr. George Mitchell is recognized for a lifetime commitment to family medicine. By Gina Kimmey

[SCHAUMBURG] George T. Mitchell, MD, of Marshall, has been named the 1993 Family Physician of the Year by the Illinois Academy of Family Physicians' board of directors. Honored July 23 during the IAFP's 45th Annual Meeting Delegate's Luncheon, Dr. Mitchell was selected from a group of 12 family physicians nominated by their patients and colleagues.

"There will never be another doctor like him," wrote one of Dr. Mitchell's nominators. "Not only is he the doctor of the year, he is the doctor of a lifetime." Dr. Mitchell was cited for being a role model and for demonstrating his commitment to family medicine, his patients and the community. He is credited with helping improve medical care delivery systems and public health for the Marshall community during his 51 years of practice.



Michael Candee

Dr. Mitchell

To be eligible for the Family Physician of the Year award, doctors must be in active practice, spend at least 50 percent of their practice time providing direct patient care, maintain hospital and office practices, be an IAFP member in good standing and participate in community service.

When his military service ended in 1946, Dr. Mitchell returned to Mar-

(Continued on page 23)

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REPORT FOR *Illinois Physicians*

MEDICARE
THE COMPARATIVE PERFORMANCE REPORT
(CPR) PROGRAM

Section 6102(b) of the 1989 Omnibus Reconciliation Act (OBRA) requires Medicare Part B carriers to "monitor and profile physician billing patterns within each payment area or locality, and to provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality." The requirements of this legislation are met through the Comparative Performance Report (CPR) Program.

CPRs compare the utilization patterns of physicians in the same specialty and locality. Utilization norms are calculated by determining the average number of services billed per 100 beneficiaries treated. Physicians who significantly exceed the peer group norms will be sent a CPR describing the procedures or services that are billed at a higher rate than their peers and, also, to what extent they have exceeded the peer group norms. This process allows the recipients of CPRs to conduct an independent assessment of the appropriateness of their utilization, coding, and billing practices.

Physicians will be selected to receive a CPR based upon an analysis of postpayment claims data for the January - June 1993 time period. In September, this carrier will send CPRs to approximately 400 physicians (our current database includes over 21,000 physicians). The CPR program is an educational effort that is intended to inform physicians that they have billed Medicare for an unusually large number of services or procedures in comparison to their peers. Each CPR letter will include a Medicare name and telephone number for a CPR physician to contact to personally discuss his/her utilization patterns. **Although physicians receiving a CPR report are not required to respond,** we will be pleased to discuss individual CPR information.

We acknowledge that the CPR information provided may not incorporate certain important characteristics of practice such as case mix, subspecialty and site of service. In fact, an improper specialty classification will invariably "trigger" a CPR report. For this among other reasons, every physician should have his/her specialty properly coded in the Medicare system; corrections can be submitted to:

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In this manner, all future utilization analyzes will compare your practice patterns against your specialty peer group norms.

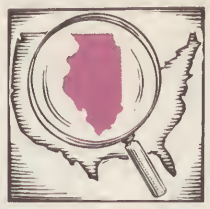
In summary, the purpose of the CPR program is to educate physicians as to their practice patterns relative to peer group norms.

(Issue: 08/13/93 - DB)

Sangamon County gears up for new free clinic

ACCESS: A community bands together to cure its own health care problems. By Gina Kimmey

[SPRINGFIELD] For years the physicians of Sangamon County, like physicians everywhere, have gone out of their way to provide care for those who fall through the cracks in the current health care system. But when lab work or hospital admittance is necessary, often physicians can offer little or nothing to patients who have no insurance and no way to pay. After attending the ISMS-sponsored indigent care seminar in Joliet last November, Sangamon County Medical Society President Jane L. Jackman, MD, suggested a free clinic to serve Sangamon County and neighboring Menard County.



"We asked our membership who would be interested in volunteering, and the response was overwhelmingly positive," Dr. Jackman said. "More than 85 doctors indicated they were willing to help. The idea had been going around for several years, but after the seminar and hearing about other projects, we were very encouraged to start planning."

Shortly after the seminar, a steering committee was formed, initially composed of 12 physicians and several members of the Sangamon County Medical Society Alliance. The group is chaired by Springfield pediatrician Virginia M. Dolan, MD.

"I've been interested in getting a free clinic in the area for some time, so when Dr. Jackman presented the idea, I immediately signed on to help," said Dr. Dolan. "In my practice, I have seen cases where I offered my services free of charge, but when it came time for blood work or admission, I hit a dead end. It's frustrating. In my office I am limited as to what I can do."

As word spread, the steering committee rapidly grew to more than 30 members. In addition to area physicians, several nurses, pharmacists and a lawyer offered their services. Community hospitals offered to accept patients referred by the clinic on a rotating basis. On May 11, the articles of incorporation for Sangamon Valley Community Clinic were issued by Illinois Secretary of State George Ryan. They were later amended to reflect the facility's name change to HealthFirst Community Clinic.

A 27-member board of directors was formed, with Dr. Dolan serving as chairman and Kathy Pearson, an ISMS Alliance representative, serving as vice chairman. The board includes members from the physician, hospital, pharmacist, business and church communities.

Earlier this summer, a group of 25 volunteers traveled to Peoria to tour the Heartland Community Clinic, a free clinic that opened in December 1991. "It was a very positive experience, especially for those who hadn't attended the [indigent care] seminar, to see an actual free clinic functioning – and functioning well," Dr. Jackman said.

With an outpouring of community support and a $25,000 grant from Springfield's Memorial Medical Center Foundation, the HealthFirst board hopes to open the clinic early next year. It will be located at First Presbyterian Church, 321 S. 7th St. in Springfield. The clinic will treat low-income residents in Sangamon and Menard counties who do not qualify for Medicaid or public aid. Each patient will be asked to donate no more than $5, but no one will be denied service because they cannot afford to pay.

"Our aim is not to replace any of the services being offered by any other individual, group or organization," said Dr. Dolan, "but to reach those people who, without our help, might fall through the cracks and not receive the medical intervention needed."

Dr. Dolan said her main concern now is offering organized and accessible care to people who have nowhere to go. "The key words are organized and accessible. I have never met a doctor who hasn't provided free care to someone, but it's not accessible for everyone. People often have a hard time expressing their need or admitting their inability to afford health care services. We need to get an organized system, so that people in need, especially the working poor, have someplace other than an emergency room where they can receive quality health care."

Dr. Jackman said starting up the clinic has been a positive experience. "There are a great many people willing to work hard to see this thing through. It has really reaffirmed my faith in human nature and the altruism of physicians."

Physicians interested in volunteering at the clinic may contact the Sangamon County Medical Society at (217) 525-0765. ■

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Foundation aids needy students

COUNTY UPDATE: The DuPage County Medical Society Foundation continues a grant program for medical careers. By Anna Brown

[GLEN ELLYN] Upholding a tradition begun in the mid-1960s, the DuPage County Medical Society Foundation awarded 10 scholarships this year to area students entering medical or allied health education programs. The presentations were made at the June 16 meeting of the foundation's board of trustees.

The grants are awarded to "any needy person in an allied health field," said Joseph R. O'Donnell, MD, a foundation board member. At this year's presentation, two medical students received scholarships of $1,000 each. Other scholarships were granted to students embarking on careers in nursing, psychiatric nursing, pharmacy, respiratory therapy and occupational therapy.

"The foundation offers 10 to 15 scholarships a year, depending on what it can raise," said Roseann Tronvig, spokesperson for the DuPage County Medical Society. Tronvig noted that the society and the foundation are separate entities. "We receive 200 applications a year. Recipients may enroll in the medical program of their choice. The first criterion is that students be highly qualified academically and second that they be in need."

The foundation was created after distribution of the Salk polio vaccine began throughout the county and state in the 1960s. The vaccine cost 50 cents per dose, and many professionals and organizations donated their time and money to administer the program. "We were sponsored by doctors, nurses, pharmacies – all professional people," Dr. O'Donnell noted. "People sent money, and we gave thousands of doses." "People came out of the woodwork to help kids," Tronvig added.

> *People sent money, and we gave thousands of doses. People came out of the woodwork to help kids.*

At the end of the vaccination initiative, the medical society had accumulated $50,000 more than the funds needed to administer the vaccines throughout the county. These excess funds were used to create the foundation; the scholarship program began in 1965, Tronvig said.

Now the foundation is funded through endowments, donations and benefits, such as a recent Chicago architecture riverboat tour held Aug. 8. The foundation still maintains reserves of about $50,000, Dr. O'Donnell added.

In addition to presenting student scholarships this year, the foundation also donated $5,000 to the DuPage Medical Clinic in Wheaton, a free clinic that opened 3½ years ago.

ALSO IN DUPAGE COUNTY, the medical society is continuing its two physician speaker programs, the Podium Program and Partners for Young Lives. The Podium Program dispatches physicians to local nonprofit groups to address health topics including AIDS, hepatitis, tuberculosis, living wills, organ transplants, violence and the physician-patient relationship.

"Our whole membership is involved in the program," Tronvig said. "The community has also been very receptive. It has been going very well."

Partners for Young Lives is an adaptation of a program developed by the AMA. It pairs physicians with lawyers to speak to schoolchildren about the dangers of drug and alcohol abuse. The physician provides a medical perspective, and the lawyer discusses the legal aspects. DuPage County has administered the program for nine years, Tronvig said. Other Illinois counties, including Winnebago County, have instituted similar programs.

Speakers programs are also available through ISMS to address senior groups. ISMS' physician speakers bureau is one component of its Partners for Health Program, which provides senior citizen groups with information on issues important to them, especially physician-patient communication. Physician speakers also discuss topics pertinent to older audiences, such as diabetes, heart disease, arthritis, Alzheimer's disease, medication and advance directives.

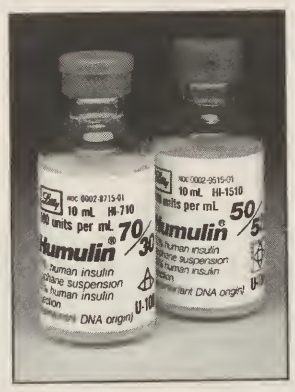
Physicians interested in joining the speakers bureau may contact the ISMS public relations department at (312) 782-1654 or (800) 782-ISMS. ■



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EDITORIAL

Kicking the habit made easier

Congratulations to the state legislature for adding another incentive to help Illinoisans kick the habit of smoking and prevent the debilitating diseases it causes. This session, the General Assembly passed a 14-cent-per-pack tax on cigarettes, bringing the total tax to 44 cents per pack – the highest in the Midwest and one of the top five highest in the United States.

In addition, legislators passed a 20-percent tax on the wholesale price of noncigarette tobacco products such as snuff, cigars, pipes and chewing tobacco. Prior to this increase, Illinois was one of only eight states in the nation that did not tax these items.

The tobacco taxes will serve a dual purpose. They – along with a new $1.50-a-day licensing fee on geriatric nursing home beds – will replace the unpopular $6.30-per-day "granny tax" that had been shifted onto private-paying residents of nursing homes.

Supporting these taxes were many health care organizations, including ISMS, the AMA, the American Cancer Society, the Illinois Hospital Association, the American Association of Retired Persons, the American Heart Association and the American Lung Association.

The media got into the act, too. Newspapers providing editorial support included the *Chicago Tribune*, the *Chicago Sun-Times*, the *Daily Herald*, the *Rockford Register Star*, the *Springfield State Journal Register*, the *Decatur Herald & Review* and the *Kane County Chronicle.*

Just how important are these taxes? Every 10-percent increase in the overall price in a pack of cigarettes creates a corresponding 10-percent decrease in teen smoking, according to the Illinois division of the American Cancer Society. A public opinion poll conducted for the organization in early 1993 showed that three out of four Illinoisans supported a cigarette tax increase, more than double the number who supported higher taxes on soft drinks or gasoline.

The tax hikes are expected to generate $105 million, according to the Illinois Department of Public Aid. And, after all, why shouldn't the state benefit from smoking? It is a very expensive habit for Illinois. It destroys lives, as evidenced by the estimated 400,000 people nationwide who die annually of lung cancer, heart disease and other ailments linked to smoking, according to the U.S. Department of Health and Human Services. It directly and dramatically increases health care costs. It reduces worker productivity. In short, there is no good use for tobacco. We hope that raising the price through taxation will prod smokers to quit and prevent nonsmokers from starting.

PRESIDENT'S LETTER

Be prepared for psychological impact of flooding

By Arthur R. Traugott, MD



Unfortunately, the flood's devastation won't end with subsiding floodwaters.

Most of the physical impact of the flooding in downstate Illinois has, by now, registered on its victims. In some cases, broken levees and water rising at the rate of several inches an hour have nullified weeks of sandbagging. People have watched their homes and their livelihoods float away. We know the public health risks caused by contaminated floodwater, but we don't always think about the psychological impact of disasters on their victims.

Just as there are stages in the grieving process, there are psychological stages in recovering from disasters. At the "inventory" stage, victims become aware of the extent of destruction. They show unusual strength and drive as they contact fellow survivors and search for any remaining possessions. During the "rescue" stage, people receive medical, physical and psychosocial support. Most individuals begin to show stress reactions at this phase. The "remedy" stage provides long-term rebuilding, which may take a year or longer. Finally, during the "recovery" period, victims have completed their grieving.

As part of the consequences of the flood, physicians should expect a high incidence of depressive reactions. These reactions are usually strongest soon after the disaster, but some victims may take longer to experience them. Symptoms may persist and become more intense if they aren't resolved early in the crisis. People at high risk of depressive reactions include the bereaved, the severely injured, people with prior psychiatric illnesses, children, the elderly, individuals of low socioeconomic status, those experiencing stress from many sources, and individuals with few or no social support systems.

Typical feelings include disturbing memories or nightmares about the event, feelings of anxiety and/or depression, sleeping problems, irritability, and problems with concentration. Physical symptoms may include nausea, vomiting, headaches, diarrhea, shortness of breath, palpitations, dizziness and difficulty swallowing. These symptoms are temporary and are a normal response. People often try to avoid remembering the event, as well as their feelings about it. Of course, this avoidance can be a problem if it prevents victims from working through the recovery stages.

There are techniques that victims can use to alleviate stress symptoms – the primary one being to take good care of themselves. They should try to keep their usual sleep patterns and avoid any stressful activity before going to bed; eat a healthy diet; avoid alcohol, caffeine or other drugs that may worsen anxiety; and get exercise. Social and psychological support is vital. Victims need a few friends or relatives they can talk to about their feelings. People who lack these resources should consider joining support groups or seeking professional help. After most recent disasters that have been studied, the people who watched the most television or read the most newspapers had more difficulty resuming their lives, so people should do these activities in moderation.

Children have special problems with disasters like the flood. They are particularly sensitive to their parents' worries. Parents should admit their concerns to their children and emphasize their ability to cope with the situation. Children may re-experience the traumatic event several months or even years after the actual event.

Unfortunately, the flood's devastation won't end with subsiding floodwaters. But physicians who recognize signs of psychological trouble can play an important role in the recovery of victims by referring them to a support group or a psychiatrist.



"He hasn't been himself lately. Is there any way you can make sure that continues?"

GUEST EDITORIAL

In defense of physicians

By William W. Parmley, MD

This "Editor's Page" was prompted in part by a brief essay in *Newsweek* titled "Suddenly I'm the bad guy," by Henry Scanlan, president of a successful photo marketing agency. He reflects on the fact that because he earns more than $100,000 a year, he is considered a member of an "economic elite," which in the eyes of the current administration, has been "getting away with it." His description of the current political rhetoric that characterizes him as not paying his fair share or as being what's wrong with America sharply reminded me of the rhetoric now being used to denigrate physicians.

In defense of all of us, I wish to remind our current administration of some important attributes of the medical profession.

1. It is difficult to find a more dedicated and hard-working segment of society. The recent guidelines of the Accreditation Council on Graduate Medical Education to limit the duty hours of residents to 80 hours per week reflect the hard work and dedication that we have always assumed to be part of our profession. All of us work long hours and understand the importance of responding to emergencies at any hour of the day and night. If long hours and dedication are part of the American work ethic, then we are examples to the rest of the country.

2. Despite the improper actions of a few physicians, we represent the most ethical profession in our country. We seem to be doing far better in this regard than politicians, lawyers and businesspeople. Beginning with the Hippocratic oath, all of our subsequent creeds and guidelines have stressed ethical behavior. We discuss these issues frequently in the hospital, on rounds and in conferences. It is gratifying to observe the high standards of my colleagues and their desire to do what is right and best for each patient.

3. We represent one of the best volunteer forces for good in this country. I have always been impressed by the magnitude of this effort, which takes many forms in our communities and nation. Our activities in organizations like the American Heart Association and the American College of Cardiology, which are designed to educate the public, improve medical care, combat smoking behavior, and so forth, are laudatory. Most of the physicians I know are active in religious, civic or community organizations. They sit on school boards, support the fine arts and otherwise promote the common welfare. Many physicians serve as volunteers in free clinics and other humanitarian programs, and *all* physicians treat many patients without charge. I believe that these volunteer activities of physicians have been and will continue to be a powerful force for good in our communities, our country and the world.

4. Physicians contribute importantly to the economic health of the country, not only as taxpayers but by providing jobs for their staff in the health care system. We have always been loyal Americans, supporting the fundamental values of our Constitution. Since all of us have gone through difficult economic circumstances in our training, we understand the treasured promise of this country, whereby it is possible for anyone to improve his or her condition through hard work and sacrifice. No, we are not what's wrong with America.

As a member of this "economic elite," I believe we have been unjustly singled out by rhetoric that can only cause unnecessary divisiveness. It is interesting to note that patients themselves appear to have another view and almost always express satisfaction with their personal physicians despite some dissatisfactions with the health care system. In the difficult times ahead, it is clear that we will be called on to maintain our substantial contributions to society. In these times it would be nice if our current administration appreciated us as much as we appreciate the opportunity to be Americans.

Dr. Parmley, a San Francisco cardiologist, is editor in chief of the Journal of the American College of Cardiology.

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GUEST EDITORIAL

It's 2003: Will CLIA '98 ships pass muster?

It was 1998 when the U.S. Congress passed the Commercial and Luxury Vessel Improvement Act (known as CLIA '98) in an attempt to put an end to disasters at sea. However, it took four more years to develop the administrative regulations needed to enforce it. Now, in the year 2003, it has been operational for a year, and we have done an investigation to determine the impact of the new law on the mariners directly affected by it. You may be surprised by our findings – or you may not be!

Large ships are covered differently in the new regulations than smaller pleasure boats, being placed in a "highly complex" category. Some tanker groundings had led to massive oil spills, and the federal government had concluded that tighter controls on navigation practices were needed to prevent such catastrophes in the future.

The captain of the giant tanker, Noxxe Zedlav, gave us a tour of his vessel's wheel room. We saw the sophisticated navigational equipment that has been on board since the ship was launched many years ago, as well as the redundant devices and procedures required by CLIA '98. We also met the clerks who are on duty around the clock whenever the vessel is under way, recording the results of the mandated Quirk Containment (QC) and Provide Tidiness (PT) programs, checking printouts of the statistical calculations done by the on-board computer, and generating reports to be scrutinized by the government inspectors who may appear by helicopter, unannounced, whenever the weather permits. The captain was unable to identify any way in which operations were truly safer than before, however. "Occasional foul-ups occur when human nature is involved," he said. "We just document them with a higher degree of sophistication now."

The situation was quite different when we interviewed the owner of a more modest, family-sized cruiser. He, too, was required to obey the "moderately complex" standards. Finding room for the newly required navigation equipment on such a small boat, where every space was already utilized, proved to be difficult. He finally solved the problem by removing the vessel's "head" and installing the instruments right next to the washbowl. The toilet paper holder was replaced by a longer device to hold rolls of computer paper. "One's about as useful as the other," said the skipper.

Our last interview was with the owner of a sailboard, which is little more than a surfboard with a sail on it. "I qualified for the 'waived' category under CLIA '98," he said, "because my boat is less than 10 feet long and doesn't have a motor. However, I still have to register and pay a substantial fee every two years, and I must keep navigation records on board at all times, even though I never sail out of sight of land."

His solution to the record-keeping requirements was ingenious, but not completely satisfactory. He bought a small dinghy, mounted a waterproof filing cabinet in it and towed it behind his sailboard whenever he went out. When we asked how this had worked for him, he said: "It really slowed me down, but I kept going until an inspector showed up in a powerboat one day while I was out sailing. At first I thought he was going to try to get on board with me, which would have assured a quick swim for both of us. Instead, he climbed into the dinghy, opened the filing cabinet, inspected my records and wrote me up because I didn't have a compass on board. That's when I decided to give up sailing."

Lest readers think that all is not well with CLIA '98, we must point out that the new law has had a substantial effect in reducing the nation's unemployment rate, because so many people are being recruited to work as inspectors. Applicants must be able to read and write – and preference is given to those who can swim.

Since the author must also deal with CLIA inspectors, this article was submitted anonymously.

Reprinted with permission from Ohio Medicine, *May 1993.*

Illinois groups sponsor career opportunities day

Are you an internal medicine resident or fellow looking for a practice opportunity? Are you looking for a partner or a new practice? Does your practice need more internists? Are you interested in learning more about jobs for internists? If so, the upcoming Career Opportunities Day for Internal Medicine may help you.

Slated for Sept. 18 in Chicago, the job fair will provide an easy way for internal medicine residents, fellows and practicing internists from Illinois, Wisconsin and Indiana to learn about career opportunities from other physicians, group practices, clinics, hospitals, recruiters and HMOs. The event is sponsored by the Illinois Society of Internal Medicine, the Illinois Associates Council, the Illinois Chapter of the American College of Physicians and the ISMS Resident Physicians Section. Exhibits will be open from 11 a.m. to 2 p.m.

The job fair will also feature educational meetings addressing contract negotiation, recruiter evaluation, interview preparation and overviews of medical practice types. The sessions will be held from 9:30 a.m. to 11 a.m.

Career day will be held at Rush-Presbyterian-St. Luke's Medical Center, Room 500. To obtain registration materials, contact ISIM at (312) 263-7150. ■



Some regulations are getting us nowhere fast.

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MEDICAL LEGAL GUIDELINES

PAGE 11

ISMIE Update

Enterprise liability – a mechanism for shifting costs

PAGE 10

Nine of 10 policyholders happy with ISMIE

A new Exchange survey measures physician satisfaction and the service initiative's progress. By Gina Kimmey

To help identify policyholders' priorities and expectations, ISMIE asked its insureds what they think about professional liability in general and the Exchange in particular. The results are in, and the good news is that more than 80 percent of current policyholders are not at all likely to change to another insurer.

Overall, nine out of 10 policyholders have a "favorable" impression of the company, with almost half having a "very favorable" impression. Seventy-two percent said their impressions were related to the service they received from ISMIE employees. When asked to rate in importance a list of five aspects of employee performance, policyholders ranked accessibility and knowledge first and second. On a scale of one to 10, both aspects averaged more than eight on an ISMIE employee performance scale.

Policyholders who have faced a claim tended to rate ISMIE employee performance higher than did other policyholders, possibly because they've seen firsthand the excellent claims and defense benefits of ISMIE, noted Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. More than 70 percent said their contact with ISMIE employees met their expectations, and 18 percent said the contacts exceeded their expectations. Respondents cited prompt and supportive service, commitment, a courteous professional attitude, and knowledge as factors influencing their opinions.

"The goal of the Physician-First Service initiative is to produce a more accessible, user-friendly company," said Dr. Jensen. "The positive responses received from physicians who have had the most experience with the company reassure us that we are moving in the right direction."

Conducted by the independent research firm Coldwater Corp., the survey polled policyholders about their needs and expectations, ISMIE performance and attitudes toward specific insurance issues and policies. Out of 10,878 surveys mailed to policyholders, professional corporations and group clinics, 2,829 were returned. A phone survey of 501 policyholders was also conducted.

"I've been conducting customer satisfaction surveys for nearly 20 years, and these are some of the best results I've ever seen," said Mary Lukens, a Coldwater researcher and partner. "It has been 1½ years since the [ISMIE] Board and senior management committed themselves to Physician-First Service and placed it at the top of their agenda. That commitment is obviously paying off."

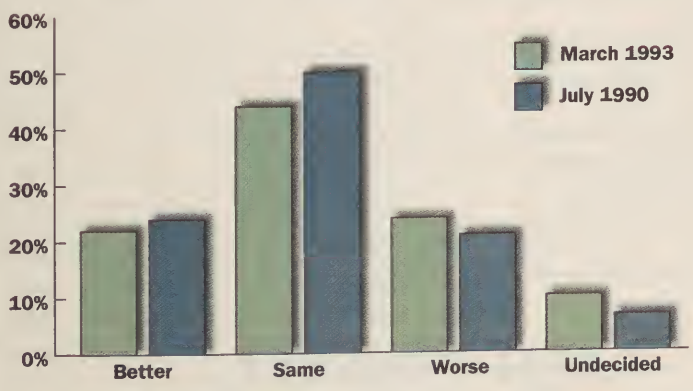
"We hoped the survey would also tell us which areas of service we needed to improve," said Dr. Jensen. "Our No. 1 priority in providing professional liability protection is the policyholder-owner. We are very encouraged to see that 80 percent of our physicians are happy with the service they receive, but we'll continue working to bolster our service to meet the needs of the other 20 percent."

The not-so-good news revealed in the survey is that some policyholders are not aware of many of the benefits for physicians, as ISMIE physician-owners. As a physician-owned insurance company, the Exchange provides policyholders with the unique benefit of true peer review, Dr. Jensen said. "ISMIE policyholders can take comfort in knowing that no settle-or-defend decision is made and no underwriting changes are undertaken without other physicians first reviewing the facts." All ISMIE programs and policies are developed by

(Continued on page 14)

Professional liability situation

The survey asked policyholders if they think the professional liability situation had improved, stayed about the same or worsened over the past few years.



Source: ISMIE Policyholder Survey
February 1993

MALPRACTICE ROUNDUP

Judges to decide on expert testimony

The U.S. Supreme Court ruled that federal courts will serve as "gatekeepers" to decide whether to admit expert testimony as evidence, the AMA reported. Spurred by a case to determine whether Bendectin caused birth defects, the high court's decision means trial courts are responsible for assessing the validity of the scientific reasoning of expert testimony and the testimony's application to the facts. Bendectin is a morning-sickness drug prescribed to pregnant women from 1956 to 1983. The Bendectin case was remanded to the lower courts for rehearing.

The AMA and 15 other members of the AMA/Specialty Society Medical Liability Project filed an amicus brief in the case. The groups argued that publication in a peer-reviewed journal is a "significant indicator" that a hypothesis or study is truly scientific. In addition, they said that in cases in which, after many years of investigation, there is no peer-reviewed literature supporting the issue, the "scientific knowledge" standard would not be met. The court agreed. Viewing the ruling as a positive step toward eliminating "junk science," organized medicine hopes the decision will reinforce the idea that trial courts should be more careful in determining which expert witnesses are truly knowledgeable about particular subjects. ■

CNA to pay $11.4 million for libel

A state court jury has ordered CNA Insurance Cos. to pay $11.4 million – half in punitive damages – to an orthopedic surgeon who claimed CNA employees libeled and slandered him by spreading rumors of drug use. In a 1985 arrest, police found 30 g of cocaine in the physician's possession. But the physician said that after he stopped using drugs, rumors of his drug use continued.

As reported in *Business Insurance*, the 1989 suit claims that CNA conspired with other insurance companies, lawyers, doctors and news organizations to ruin his practice. The jury awarded $4.99 million to compensate for damage to his past business relationships and $713,000 for damage to prospective relationships. An earlier $34 million award was overturned on appeal in 1992. ■

Hospitals sue Blue Cross for antitrust

In a suit filed in June, nine New Jersey hospitals are suing Blue Cross and Blue Shield of New Jersey's new HMO, claiming the 56-hospital network violates antitrust laws. The hospitals, all excluded from the network, say the plan violates antitrust laws, because it prohibits network hospitals from charging other insurers less than the network rate unless the hospitals automatically give Blue Cross and Blue Shield of New Jersey the same lower rate, *Business Insurance* reported.

The suit also charges that Blue Cross of New Jersey is trying to create a monopoly of the state's nongovernment health care market by selecting 5,800 of New Jersey's 17,000 doctors as network physicians and influencing them to direct patients to network hospitals. It also challenges the plan's intent to reimburse network hospitals within 48 hours, while waiting up to 60 days to reimburse non-network hospitals. ■

Enterprise liability – a mechanism for shifting costs

The following is adapted from a paper written by the Physician Insurers Association of America. All statistics are from PIAA.

As part of its health care reform initiative, the Clinton administration has proposed enterprise liability to remove malpractice liability pressures from individual health care providers. Under enterprise liability, practitioners would receive federal immunity from lawsuits; all legal actions resulting from alleged individual negligence would be brought against Accountable Health Plans – the primary deliverers of health care services, resembling today's large managed care plans.

Physicians, currently the largest purchasers of medical malpractice insurance, would allegedly no longer need it. AHPs would provide this protection by purchasing liability insurance for all practitioners, corporations, hospitals and themselves. Typical AHPs would be formed by large metropolitan or statewide organizations that included dozens of hospitals and perhaps thousands of physicians and other practitioners. Instead of having many small policies tailored to individual insurance risks, the insurance market would include a few large policies covering general mega-institutional exposure.

Plaintiffs would no longer be able to sue their physicians, but would instead sue faceless AHPs. Sixty-five percent of all medical malpractice claims stem from hospitals, and hospitals would continue to be the bull's eye of the institutional target. Physicians would probably become witnesses in legal actions, rather than defendants. Cases arising from treatment provided by many individuals would be combined in one claim against the AHP, requiring only one defense and possibly resulting in administrative savings. The Clinton administration has said, however, that any savings might be equal to, or even exceeded by, the costs of administering enterprise liability.

Proponents of enterprise liability say the benefits might be the following:

- Individual physicians could not be sued.
- Individual physicians might no longer have to pay medical malpractice premiums or worry about tail coverage, as they do under the current claims made coverage, because the AHP would pay.
- Administrative savings would accrue through reduced defense costs and perhaps by aggregate coverage, resulting in reduced malpractice insurance costs. Large insurance providers would compete for the extensive liability coverage required by the AHPs, which could reduce malpractice insurance costs.
- Total indemnification awards would be reduced because there would be fewer defendants.

Opponents of enterprise liability point to the following problems:

Only one in three malpractice claims brought by plaintiffs and their attorneys result in an indemnity payment; the other two are won by the defendant, dropped by the plaintiff or dismissed by the court. These claims are costly to defend. Further, malpractice claims are reported to insurers approximately two years after the alleged incident has occurred and are concluded six to eight years after the incident, with the delay caused by the tort resolution system. Enterprise liability would not change these unfair and inefficient aspects of the current tort system. In fact, enterprise liability would do nothing to improve the tort system's inefficiency, which causes more than 43 percent of money spent on claims resolution to go to attorneys.

Today, most insurance is provided by physician- or hospital-owned carriers, or self-insurance plans, which are in business to reduce costs, not to make profits. Even so, average malpractice indemnity payments have doubled over the past

(Continued on page 12)

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

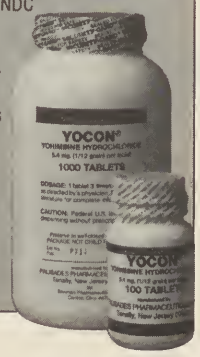
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Guidelines on parental notification explained

MEDICAL LEGAL GUIDELINES

PARENTAL CONSENT is necessary for most medical and surgical procedures performed on minors. Although physicians may provide certain services to minor patients without parental consent, there are some limitations, as documented in the Consent by Minors to Medical Procedures Act [410 ILCS 210/0.01 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 111, pars. 4500 – 4505]).

All patients under the age of 18 are considered minors under the law. However, all minors who are parents, married or pregnant may consent to medical or surgical procedures without their parents' consent, because they are considered to be of legal age. Physicians are exempt from obtaining parental consent if they are providing emergency treatment or first aid to a minor. Parental consent is not required by law if physicians are providing services to a minor who is a victim of sexual assault or abuse and if obtaining such consent is not reasonably feasible without affecting the minor's health.

Nothing in state law indicates what type of consent may be honored if a minor patient seeks care from a physician without a parent present.

BIRTH CONTROL SERVICES may be delivered by all physicians licensed in Illinois to practice medicine in all its branches, including physicians practicing in federally funded clinics and Title IX clinics, according to the Birth Control Services to Minors Act [325 ILCS 10/0.01 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 111 1/2, par. 4650 et seq.]). Specifically, birth control services may be rendered to minors who are married, are parents themselves, are pregnant, or have the consent of their parents or legal guardian. Such services can also be delivered to minors if failure to provide these services would create a serious health hazard or if the minor patient is referred by a physician, clergyman or Planned Parenthood agency.

VENEREAL DISEASE and chemical abuse diagnosis and treatment may be provided to minors by physicians, as outlined in the Consent by Minors to Medical Procedures Act [410 ILCS 210/5 (1992)], formerly [Ill. Rev. Stat., ch. 111, pars. 4500 – 4505]). Specifically, physicians may render such services to a consenting minor between the ages of 12 and 18 without parental consent. When providing services with a minor's consent, physicians should make reasonable attempts to involve the patient's family, provided the treating physician believes that such involvement would not be detrimental to the minor, according to the Act. Legislation has been passed modifying these requirements by permitting health care workers to provide more services to children who live in families with problems of drug or alcohol abuse.

However, parental notification must be given for physicians to provide minors with more than two treatment sessions for alcohol abuse. In addition, without parental consent, mental health facilities may not provide more than five 45-minute outpatient sessions to treat minors aged 12 to 17 for alcohol abuse.

CHILD ABUSE and neglect must be reported by physicians to the appropriate state authorities. Physicians may not allege that such communications with their patients are privileged, according to Illinois law [325 ILCS 5/4 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 23, par. 2054]. Consequently, communications and records concerning reports of suspected abuse and neglect can be obtained by law enforcement and child welfare agencies to facilitate investigations of these reports.

PARENTAL CONSENT POWERS with respect to minors' health care matters under the terms of a divorce decree are spelled out in the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/101 et seq. (1992)], formerly [Ill. Rev. Stat., ch. 40, par. 101 et seq.]. Under Illinois law, both custodial and noncustodial parents have the right to access information and records, and to make health care decisions for their minor children in accordance with the terms of any divorce decree or custody order. Under a joint custody award, each parent's rights, powers and responsibilities for the care of children, including health care matters, are specified in the Act (sec. 602.1(d)). Therefore, unless physicians are given notice of the terms of the divorce decree, doctors acting in good faith may assume parents have the right to access health information about their child. When physicians know there has been a divorce in the family, they may wish to ask the custodial parent about

(Continued on page 12)

Breast of chicken



3-oz. cooked serving of chicken breast

Best of pork



3-oz. cooked serving of pork tenderloin

Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

Compare pork with chicken[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz, cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.[1] According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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Guidelines

(Continued from page 11)

any health care specifics in the decree. Physicians may see the decree and retain a copy for their records. Unless otherwise specified in a divorce decree, physicians are authorized to discuss these matters with any parent. ■

Editor's note: This is the last in a series on medical-legal issues written by the ISMS Medical Legal Council. These guidelines do not necessarily represent ISMS policy. They are intended to serve as only a guide for physicians, not specific legal advice.

Enterprise liability

(Continued from page 10)

five years. These carriers return any profits in rate abatement or in dividends to policyholders. The commercial carriers still in the market must compete on this playing field.

Enterprise liability does nothing to address these issues and introduces these additional concerns:

- The AHPs would be deep pockets for the plaintiff bar. Awards could be expected to be larger, not smaller, because of the much larger coverage limits available.
- Plaintiffs and their attorneys would sue faceless business organizations, AHPs, which could increase the number of suits. Plaintiffs and their attorneys would be more likely to bring nonmeritorious claims against an organization than against personal physicians.
- In allegations of negligence, physicians would lose their individual rights and responsibilities to defend their actions. AHPs would be more inclined to settle nonmeritorious claims – a reversal of the current practice of physician-owned carriers.
- Although individual physicians would no longer be required to purchase malpractice insurance, physicians would undoubtedly still have to share in the burden of insurance costs, probably through a reimbursement mechanism.
- Physicians' insurance policies currently follow them wherever they practice medicine. Practicing at multiple AHPs would create problems in coordinating coverage. A system that allowed physicians to make payments "in kind" through reduced reimbursement for services would require a complicated accounting system.
- Historically, relationships between medical staffs and institutions have not always been harmonious. With AHPs as umbrella corporate bodies, the physician-AHP relationship might be even

CLEAR BENEFITS FROM START TO FINISH

Proven Efficacy

Nonsedating*
The incidence of sedation with CLARITIN Tablets (8%) was similar to that of placebo (6%) at the recommended dose.

Rapid-Acting†
CLARITIN Tablets started working in some patients as soon as 30 minutes; 65% experienced relief within 2 hours.

Once-a-Day Dosing
One 10 mg CLARITIN Tablet provides round-the-clock relief.

Low Incidence of Adverse Effects
In controlled clinical trials, the incidence of reported adverse effects in patients receiving CLARITIN Tablets was similar to that in patients receiving placebo. See CLARITIN Tablets full Prescribing Information.

No Torsades de Pointes Type Arrhythmias Reported to Date
Not seen in over 5 years of worldwide clinical experience.

In a study with CLARITIN Tablets given at 4 times the clinical dose for 90 days, no significant increase in QTc was seen on ECGs.

*In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

†Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03).

New, once-a-day

Claritin®
10 mg TABLETS (loratadine)

Please see back of following page for brief summary of full Prescribing Information.

FOR THE NAS

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poorer. The proposed plan would place AHPs and physicians at odds, because each time an action was filed against them, AHPs would question the quality of care. Instead of having the courts determine liability, the new system would allow AHPs to do so. However, AHPs could not be as neutral as the courts.

• Because they bear the brunt of liability exposure, AHPs would be inclined to use management techniques to try to control malpractice risk – exerting more control over practitioners to prevent claims. In cases in which AHPs might benefit from the delivery of medical services, defensive medicine might increase. AHPs might want physicians to perform procedures that have a higher profit margin and restrict the others. AHPs would set standards of care, with the profit margin being a determinant.

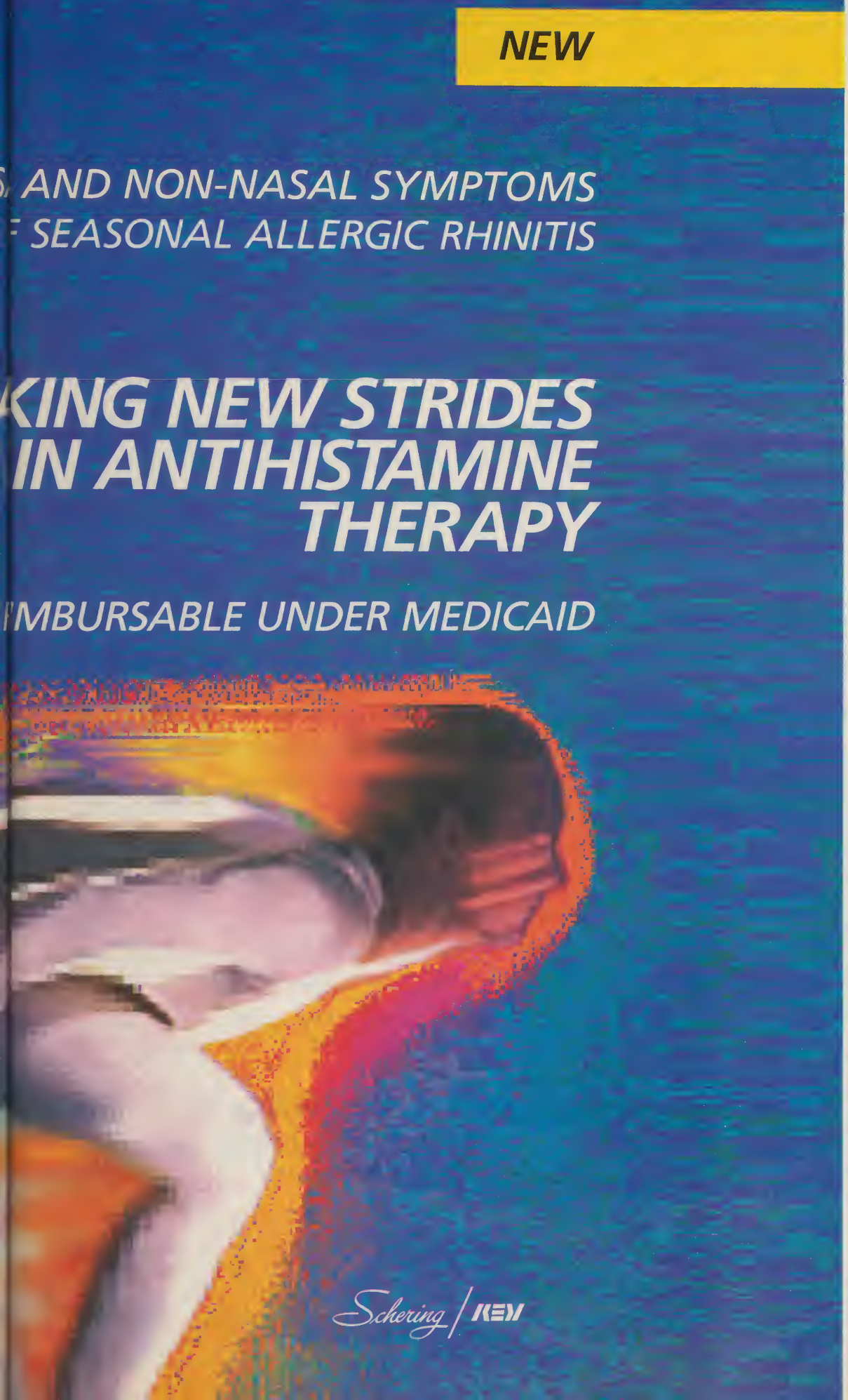
• The physician-patient relationship might become more strained because of the increased control and practice standards imposed by the corporate AHPs.

• When an action was brought against an AHP for the acts of a practitioner, and the AHP and practitioner differed regarding the merits of the action, they would become legal adversaries. Practitioners would be forced to defend their rights, possibly even the right to practice medicine, against AHPs.

• Since the AHP, not the physician, would be sued, practitioners would no longer be directly accountable for their actions. Doctors are now accountable by societal standards, which would be replaced by corporate or AHP guidelines.

• The large insurance carriers, which would be the only ones capable of providing coverage to the corporate AHPs, would again dominate the medical malpractice insurance marketplace. Physician-owned-and-operated medical malpractice insurance carriers, which now provide physician education and loss prevention services, would be replaced by the large commercial carriers. These commercial carriers are in business to make money and have no incentive to be committed to the long-term benefits of physician-oriented activities.

At best, enterprise liability would shift the burden of malpractice costs from individual providers to AHPs. Physicians would still have to defend their actions, however, and they would lose the protections granted by the courts. Those protections would be replaced by corporate standards and review procedures practiced by AHPs. Furthermore, aggregated risk in AHPs would increase the potential for larger awards and settlements, and increase, rather than decrease, malpractice insurance costs. ■



CLARITIN®
brand of loratadine

TABLETS
Long-Acting Antihistamine

BRIEF SUMMARY
(For full Prescribing Information, see package insert.)

INDICATIONS AND USAGE
CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS
CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS
General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: Drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, ketoconazole, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS
Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS
PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing.
Body As A Whole Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.
Cardiovascular System Hypotension, hypertension, palpitations, syncope, tachycardia.
Central and Peripheral Nervous System Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.
Gastrointestinal System Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.
Musculoskeletal System Arthralgia, myalgia.
Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido, nervousness.
Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginitis.
Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.
Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.
Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema; abnormal hepatic function including jaundice, hepatitis, and hepatic necrosis; alopecia; seizures; breast enlargement; erythema multiforme.

OVERDOSAGE
Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdosage, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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Survey

(Continued from page 9)

physicians, for physicians, he added.

From the survey results, ISMIE learned that although 22 percent of physicians think the malpractice situation in Illinois has improved over the past few years, 44 percent believe it has stayed the same, and another 22 percent said the situation has worsened. "The results indicated that older physicians are more likely to think the situation today is better," said Dr. Jensen. "Many younger physicians didn't experience the availability and affordability crisis of the 1970s, which led to the creation of ISMIE. Therefore, they are less likely to recognize the improvements in today's malpractice climate."

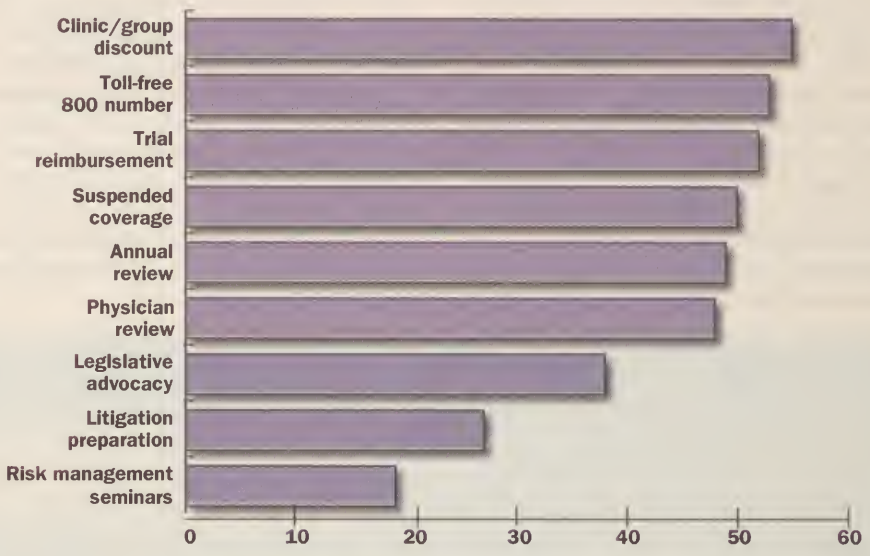
WHEN ASKED TO RATE the importance of five aspects of an insurance program, policyholders ranked aggressive defense as the most important, giving it a 9.3 on a scale of one to 10. Respondents ranked consent to settle an 8.3, the cost of premiums 8.3, equitable classification of risk 8.3 and physician ownership and management 7.3. Addressing the most and least important aspects of a liability insurance program, almost 80 percent of respondents chose an aggressive defense as most important, and 40 percent chose physician ownership as least important.

"I'm concerned that some of our policyholders seem unaware of the benefits of physician ownership – benefits not available from commercial carriers," said Dr. Jensen. "Physician ownership means that as a policyholder, you can be sure your opinion will always be heard. Examples of this are the claims review committee and the committees that review underwriting profiles of policyholders. Physicians on these committees are Exchange policyholders' colleagues and peers who are also insured. They are not nameless, faceless insurance company employees."

The survey also showed that the Exchange's risk management seminars and litigation preparation are well-known and helpful to policyholders. (See chart at right.) But some respondents need more information about ISMIE programs such as suspended leave coverage, trial time reimbursement, the toll-free 800 number, and premium discounts for clinic and group policies. Dr. Jensen said the company intends to step up marketing efforts in those areas.

"It is crucial for the Exchange to ensure that each policyholder knows and understands what it means to be insured with ISMIE," said Dr. Jensen. "We will take the results of this survey and fine-tune our efforts so that 10 out of 10 ISMIE policyholders will be satisfied with their medical malpractice insurance company." ■

Percentage of policyholders unaware of the following ISMIE services:



Source: ISMIE Policyholder Survey
February 1993



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MINI-INTERNSHIP PROGRAM

ISMS-Alliance mini-internships benefit community, physicians

Physicians throughout Illinois take time to educate community leaders about the practice of medicine.

BY ANNA BROWN

John E. Lovell, MD, a Tremont family physician, prescribed a muscle relaxant and X-ray for a male patient in his 30s. The man had fallen while skiing and had a large bruise on his side. Dr. Lovell told the patient he suspected it might be a cracked rib. Not seeming concerned, the patient said he planned to go skiing again the next day. Dr. Lovell shook his head.

The doctor's next patient, a frail woman in her 90s, was near tears as she sat on the examining table. Easing herself into the prone position, she broke down from the pain in her back. Her husband, sitting nearby, explained that his wife suffered from nearly constant pain and that she was unable to eat. The woman added that she thought she was taking too many pills.

"People talk to their doctor differently than [they talk to] anyone else," Dr. Lovell told his intern, who was there to observe the steady stream of nearly 30 patients who passed through his office between noon and 6 p.m. Before that, the intern had accompanied Dr. Lovell on hospital rounds, beginning early that morning. The doctor had carefully examined and interviewed each patient – those with heart conditions, Crohn's disease, even gangrene. Updating the patients' charts was the most time-consuming aspect of rounds.



Gregg Daniels

During her mini-internship, Sen. Karen Hasara spent time examining orthopedic patients with Sangamon County physician John R. Fisk, MD.

Dr. Lovell is a first-year participant in Tazewell County in the ISMS/ISMSA Mini-Internship Program. He is one of more than 50 physicians who participated this year in the 3-year-old joint venture between the Society, the Illinois State Medical Society Alliance (formerly the Auxiliary), and county medical societies throughout Illinois.

THE MINI-INTERNSHIP program matches legislators, community leaders and business representatives with physicians statewide. Participants spend one or two days experi-

(Continued on page 16)

Mini-internships

(Continued from page 15)

encing the everyday challenges and complexities of practicing medicine. "It is a very positive experience," said Judy Allendorph, an Alliance mini-internship coordinator for Madison County. "One of the goals is to make friends of legislators and doctors. Through the mini-internship program, the door to sharing information has been opened."

Allendorph's husband, Mark M. Allendorph, MD, a Jerseyville internist, hosted state Rep. Tom Ryder (R-Jerseyville) in February. "This was my first experience [in the program], but it will not be my last," Ryder said. "We spent most of one day doing procedures at the hospital. My strongest memory is the time [Dr. Allendorph] took with his patients. Their comfort level was his primary focus. He did his best to allay their concerns and fears."

Ryder said he was also amazed by the technology used for various procedures. "It was like a video game," he said of the equipment Dr. Allendorph used to examine a patient's intestine and colon. But despite the sophisticated instruments the physician used, "his examination and observation were crucial," Ryder said.

After Ryder had completed his one-day internship, he met with Dr. Allendorph a few days later to discuss what he had seen. "He explained everything thoroughly. He was super, showing me the same kind of patience and consideration he showed his patients," Ryder added.

State Sen. Karen Hasara (R-Springfield), another intern, also lauded the program: "I have always had a great deal of respect for the medical profession, but the program has given me greater insight." Hasara has participated in the program for three years. This year, she interned with John R. Fisk, MD, an orthopedic surgeon affiliated with the Southern Illinois University School of Medicine in Springfield. "The main thing that amazed me this year was the variety of orthopedic problems we saw. Many were very serious."

"We discussed the medical significance of the patients, not political issues," Dr. Fisk said. "I had on my agenda to communicate the disproportionate number of public aid patients that medical schools see. We need more equitable distribution between medical schools and private practices."

> *It's a chance for physicians to take a day and explain what they're doing without writing a letter. By communicating directly, they're getting their ideas across.*

Other legislative participants included U.S. Rep. Dick Durbin (D-Springfield), who was also a Sangamon County intern. Durbin spent a day with Springfield family physician Michael L. Brewer, MD.

Larry P. Stalter, MD, a family physician, coordinated the mini-internship program in Livingston County. "I got the impression that some people in the industry think we give diagnoses and that's it," Dr. Stalter said. Participants in Livingston County included a representative from Caterpillar Co. and Rep. Dan Rutherford (R-Pontiac). "The Caterpillar intern had her eyes opened on how we process forms," he noted. Rutherford hadn't realized that Medicare and Medicaid were processed on separate forms, Dr. Stalter said, adding that the legislator indicated he would investigate the possibility of combining the two forms. "The program was overwhelmingly beneficial."



Ron Ackerman

U.S. Rep. Dick Durbin (center) is a second-year intern. He recently accompanied family physician Michael L. Brewer, MD (right), on hospital rounds.

"I VOLUNTEERED BECAUSE I thought it would be a good idea for the public to see that medicine is not as cushy as everyone thinks," said Robert E. Brockman, MD, a general surgeon from Kankakee. "I also benefited because [the intern] gave me the patient's perspective on how scary surgery is. I learned to zero in and spend extra time talking to patients. And it was fun. It was nice to have someone tag along. I wish we could do it more often. People sometimes get the idea that doctors are the cause of medical problems."

Rosemary Brockman served as the Alliance coordinator for the Kankakee County Mini-Internship Program. "I was worried about physicians' standing in the community," she said. "Ten or 20 years ago, physicians were really well thought of. The interns were pretty surprised by everything. We had a very positive outcome."

Rock Island County has one of the largest number of physician participants in the mini-internship program in Illinois. "We've [offered the program] three years in a row," said Mary Ann Stoffel, Alliance coordinator for the county. "I wanted to be more involved in legislative affairs. I thought the program would work because the key is education. We're dealing with legislators making laws that are governing our spouses."

"This is a very well-organized program," said J.H. Gardner, MD, a family physician and president of the Rock Island County Medical Society. "The experience opened a lot of eyes for interns, especially in the business aspect and in the area of record keeping."

"Interns observed that people are concerned about health care costs," said Philip T. Siegert, MD, a Rock Island general surgeon. "They learned that patients seem to like their own doctors."

"Physicians have been tremendously supportive," Stoffel said. "We've had wonderful cooperation. Physicians love what they're doing. They also enjoy a captive audience [to whom] they can show off their trade. They can share their day and their frustrations. It's a chance for physicians to take a day and explain what they're doing without writing a letter. By communicating directly, they're getting their ideas across."

For more information about hosting an ISMS-ISMSA mini-internship in your area, call (800) 782-ISMS. ■

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Poison control

(Continued from page 1)

area to take over the service," said Karen Gruder, IDPH spokesperson. "In the meantime, the other poison control centers in the state will handle the extra calls.

"Unfortunately, Illinois' poison control centers don't receive any state or federal funding," Gruder added.

"I'm concerned that there won't be a place for these calls to be channeled," said Georgia A. Davis, MD, a psychiatrist and member of the St. John's medical staff, who completed her internship in pediatrics. Dr. Davis said she is concerned that people don't realize the consequences when poisoning victims fail to receive immediate attention. Children who are victims of poisoning may experience kidney, liver or neurological disorders that require continuous care for the rest of their lives, resulting in higher costs down the road, she said.

"I see a domino effect happening," Dr. Davis noted. When the Peoria center closed, calls were transferred to a Pekin center, she said. When Pekin closed last year, those calls were absorbed by St. John's. Now, Illinois' two remaining centers, located at SwedishAmerican Hospital in Rockford and Rush-Presbyterian-St. Luke's Medical Center in Chicago, are expected to cover the entire state.

"What happens if the Chicago and Rockford centers can't take these calls?" Dr. Davis asked. "We aren't operating in a vacuum. What we do will affect people all over the state. It's not just private citizens who use the center; it's doctors and emergency rooms, too. They are all losing a valuable resource."

"This is very distressing to us," said Jerrold B. Leikin, MD, medical director for the Chicago center, which covers all of northeastern Illinois. He said calls to his center have increased 20 percent over the last five years. "We currently receive an average of 120 calls per day, but it's not unusual to have as many as 200. It's not a question of not accepting more calls; we just can't handle any more."

UNLIKE EMERGENCY ROOM staff, poison control center staff members do most of their work over the phone. "The most important element in treating a poisoning is timing; time is of the essence," said Hayner. "Doing the right thing, right away with the center's help, rather than waiting 15 or 20 minutes while getting to the emergency room, can make a critical difference in the outcome."

Currently, when an individual calls the St. John's center's toll-free number to report a poisoning, a specially trained poison-information nurse takes down the necessary information about the substance, amount ingested or area of skin covered, and weight and age of the victim. The staff member then advises the victim about what treatment to administer and whether he or she should proceed to the emergency room. The staff also makes three follow-up calls – 1, 12 and 24 hours after the initial call – to monitor progress and make any necessary referrals for further treatment. If a case requires an emergency room visit, the staff contacts the nearest hospital, informs emergency room staff of the situation and remains available for consultation.

"More than 70 percent of the cases we deal with are treated in the home; only 30 percent are referred to the emergency room," Hayner said. "So in the long run, the program is cost-efficient; it keeps people out of the hospital. This is undoubtedly a valuable service, but our quandary is how can we continue to fund a service that doesn't generate any income. It was not an easy decision for the board." The St. John's board of directors will keep in close contact with IDPH to "effect a smooth transition," she said. "We're not just shutting off the phones."

The outlook for poison control centers nationwide is bleak, said Dr. Leikin. "You could say poison control centers are 'on ventilators' right now. They are closing or downsizing all over the country. With reform in health care, people are looking for ways to save money, and a poison control center is an easy item to wipe off of a hospital's budget." ■



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Healthy Moms

(Continued from page 1)

Eligible participants in HMHK are children under age 21 and pregnant women.

"It is important for recipients to be given the opportunity to choose or to be assigned to providers in a fair and objective manner," Dr. Traugott said. "We've heard anecdotally that some patients are confused about their choices. For the program to work, recipients must be told about the full range of options available to them. Any new program has wrinkles, but if physicians or their patients have questions about the program, they should contact IDPA or ISMS for clarification."

"We clearly appreciate the critical role physicians play in HMHK," said Robert Wright, IDPA's acting director. "It is essential that we make it as hassle-free as possible. Any physicians with questions should feel free to call the First Health hot line or the Bureau of Comprehensive Health Services."

According to Arthur F. Kohrman, MD, chairman of IDPA's Medicaid Advisory Committee, more than 12,000 patients were enrolled in the program as of July 12. "This is a new program, and there is a tremendous effort to correct any problems," Dr. Kohrman said. "Every provider complaint will be investigated."

Physicians may call IDPA's toll-free physician hot line at (800) 884-5437, or the ISMS division of health care finance at (312) 782-1654 or (800) 782-ISMS. Chicago physicians may also contact the IDPA Bureau of Comprehensive Health Services at (312) 793-3080. ■

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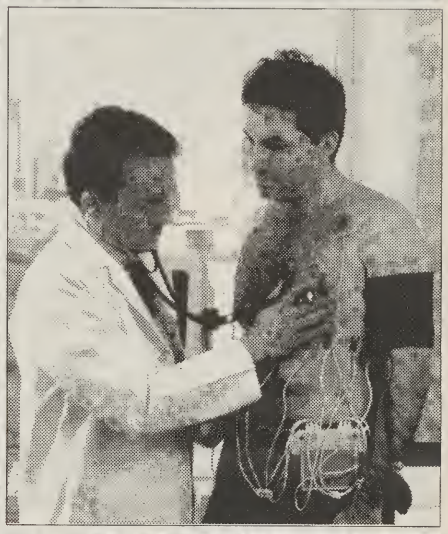
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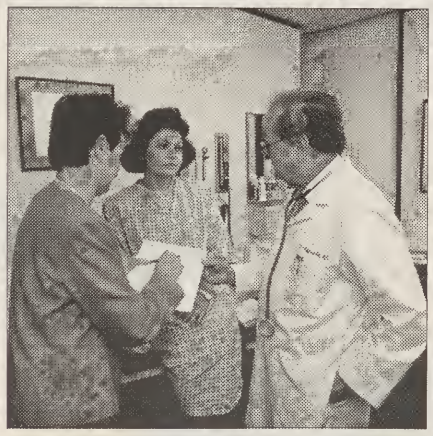
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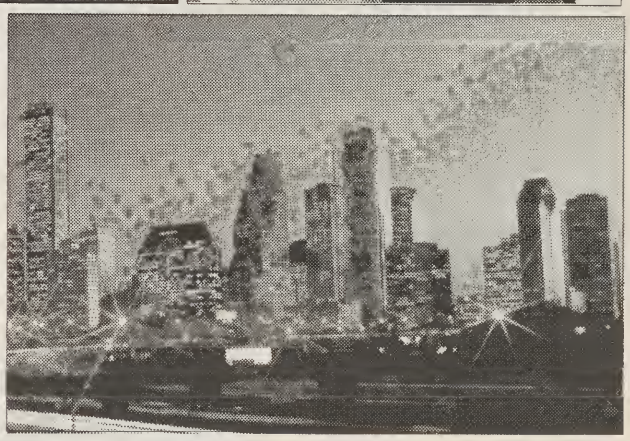
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Seminar

(Continued from page 1)

Kicking off the day with an invitation for honest and open discussion of the options facing health care providers, ISMS Board Chairman Jere E. Freidheim, MD, introduced Lee H. McCormick, MD, a Pittsburgh family practitioner who serves as chairman of the AMA Hospital Medical Staff Section Governing Council. Dr. McCormick presented an overview of physician-hospital relations.

"We have common goals: high-quality care and low cost," said Dr. McCormick. "The last 10 years have been very stormy years in our relationship. There were struggles for control, which led to problems of mistrust."

He and other speakers cited economic credentialing and exclusive contracts, as well as disregard for medical staff bylaws, as problems physicians encounter with hospitals. In turn, hospitals are concerned about physicians' organization of outside labs and imaging centers, and direction of patients to other hospitals, Dr. McCormick noted.



Michael Candee

Dr. Brown



Michael Candee

Goldsmith

Although there is a perception that the health care industry is sitting back and waiting for President Clinton's reform plan to be released, reform is already occurring in the marketplace, Dr. McCormick said. "That's why we are here today. Health care delivery is changing in anticipation of reform."

UNDER HEALTH CARE reform, the fee-for-service sector could shrink to as little as 10 percent to 30 percent of the health care system, said Jeff Goldsmith, a national adviser to Ernst and Young and president of Health Futures, Inc. "If the Clintons accomplish what they want, we could see a tripling of managed care enrollment." He said that on the basis of what is known about the Clinton plan, the system will be difficult to implement. The integrated health care necessary to enact such a plan is wrought with obstacles, he said.

"My counsel to people is to be patient," Goldsmith noted. "It took three generations to produce Kaiser and Mayo [Clinic]. It may take decades to reform the current structure."

The real challenge in reform awaits physicians who have been practicing for several years, said John F. Schneider, MD, an ISMS Third District trustee and member of the Society's ad hoc committee on health care system reform. Most physicians will be forced to choose group practice of some kind. "Few physicians completing training today would dream of a solo practice. What many physicians are realizing is that they have to choose others with whom they feel comfortable working, in terms of patient care," Dr. Schneider said.

In hospitals, the medical staff bylaws should provide physicians with an organized starting point from which they may interact and negotiate with the hospital, said Dr. Schneider. "When we can demonstrate we are capable of working together and show we can provide efficient, effective care, we can get back to the business of managing care. The strength of the medical profession comes only when we are willing to work together."

Audiotapes of the July 22 seminar are available from ISMS for $55. ■

Budget

(Continued from page 3)

kind of get used to [the delays], but at some point it gets critical. Doctors have to pay their overhead."

The financial strains caused by the program can also adversely affect the physician-patient relationship. Physicians try to be sensitive to the delays in the program, but when physicians have bills to pay, they may be forced to take out loans or ask their patients to pay as they go.

"The program is better now than it has been in years past, but physicians who treat state employees are still waiting anywhere from four to six months for reimbursement," said Craig A. Backs, MD, a Springfield internist who treats many state workers. "I generally talk freely with my patients about these matters, and they fully understand the position I am in. If they can afford to pay up front, they do; if they can't, we work something out."

Physicians who have many state employees as patients are often faced with choosing between dealing with cash flow problems and asking their patients to force payment of claims, Dr. Backs said. "The state tends to listen with a more sympathetic ear when [its] employees, not physicians, are calling."

Dr. Backs said he tries to keep the slow reimbursement in perspective. "First, the situation has improved. Second, the future depends on how the new managed care works and how much of the burden shifts to managed care plans. When I think of the reimbursements offered under managed care and the discounts given under a managed care plan, it doesn't look so bad to wait four or six months for reimbursement from the state." ■



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Flood

(Continued from page 1)

who was suffering from a summer cold but still volunteered to fill sandbags, Dr. Jackman called the state's flood relief hot line. "I thought, if this woman can go help, why can't I? So I called the 800 number and was told they didn't need food or medical care; they needed people to fill sandbags."

Directed to a farm in Nutwood – in Jersey County, north of St. Louis – Dr. Jackman and her family joined 100 other volunteers filling sandbags to reinforce a levee protecting farmland. "I was impressed by the spirit of the volunteers. There were people there of all ages – children around 6 and adults 30 years older than me, but no one complained."

Despite the volunteers' best efforts, however, the floodwaters eventually broke through the levee. But Dr. Jackman said it hasn't discouraged her from volunteering again. "If I have time, I'd like to go back and help again. These people have been just devastated."

FLOOD RELIEF COORDINATORS said money is now the most vital need in flooded areas. Responding to flooding in and around Quincy, the Adams County Medical Society established a fund called Health Aid '93 to help the county recover from flood damage. "Recovery agencies don't need supplies; they need money," said Steven R. Ginos, MD, president of the county medical society. "Funds collected by the society will be used for tetanus vaccinations and mosquito abatement programs, and some will be distributed to the Red Cross and Salvation Army for their flood relief efforts."

Blessing Hospital in Quincy has provided more than 200,000 tetanus vaccinations. Adams County public health officials are concerned about a possible encephalitis threat because the standing floodwater is facilitating a rising mosquito population, Dr. Ginos said. Contributions to the fund can be sent to Health Aid '93, % the Adams County Medical Society, 2039 Sunnybrook, P.O. Box 767, Quincy, IL 62306.

Working with local public health departments, the Illinois Department of Public Health helped administer 26,000 doses of tetanus vaccine and evacuate three long-term care facilities in flood-ravaged areas. With the state Environmental Protection Agency, IDPH has coordinated distribution of thousands of gallons of bottled water. Public health inspections of other facilities will begin when floodwaters subside, according to the governor's office.

SINCE THE FLOODING BEGAN, the governor has declared 33 counties state disaster areas, and as of July 26, he had given the White House a preliminary estimate of more than $930 million in losses to individuals, businesses and governments statewide due to the flood. That estimate includes nearly $10 million in public health and crisis counseling costs, and $258 million in infrastructure, flood control and public safety costs. To date, the president has declared 24 Illinois counties national disaster areas.

"The most effective way for citizens to help now is to contribute funds to the statewide volunteer agencies that are on the front lines working directly with victims of the disastrous flooding," said Allen Grosboll, state flood response coordinator. "Cash donations will provide the same assistance and also will help the economy of these devastated areas recover."

"The real crisis will be a very long one," Dr. Jackman added. "There will be big problems for the unemployed and the uninsured, who won't be able to get the health care they need. When the immediate crisis is over and the rain stops, these people will have still lost their homes, their farms, everything."

Individuals interested in making donations or volunteering their services may call the state's flood relief hot line at (800) 650-CARE. ■

Dr. Mitchell

(Continued from page 3)

shall and established a medical practice in his father's former office. "For many years he was the only local doctor," wrote one of his patients. "He took care of everyone – delivering babies, being in his office all day long, making house calls day or night. His application of energy to improve the world around him sets him apart and above all the other good doctors in the world."

"George Mitchell is a dedicated physician who truly deserves this great honor," said ISMS President Arthur R. Traugott, MD. "Dr. Mitchell has also served ISMS and organized medicine well, as the Society's vice president, a founding member of IMPAC and president of the Clark County Medical Society."

Dr. Mitchell's continuing efforts to improve rural health access are manifested in his duties as co-chairman of the ISMS Health Care Access Committee, which coordinates the Rural Health Speakers Bureau. The speakers bureau provides communities with information in response to common rural health problems. To schedule speakers, groups may contact the ISMS health care finance division at (312) 782-1654 or (800) 782-ISMS. ■

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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THE PRAVACHOL® DIRECTION
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Effective lipid management doesn't have to be tough

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- Excellent safety profile
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- Usual dose: 20 mg once daily at bedtime, with or without food

PRAVACHOL®

pravastatin sodium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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CASE IN POINT LOOKS AT FOLLOW-UP AND DOCUMENTATION (PAGE 6)

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PAGE 2

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • AUGUST 27 1993



Filling prescriptions for the needy

PAGE 8

OBRA '93 includes cuts in Medicare, Medicaid

FEDERAL BUDGET: Physicians will see lower rate increases in 1994. By Anna Brown

[WASHINGTON] The new federal budget signed by President Clinton includes significant cuts and changes to Medicare and Medicaid. Among the changes many physicians will see from the Omnibus Budget Reconciliation Act of 1993 are lower fee increases and expansions in the limits on self-referral procedures. Under the new budget, Medicare will lose a total of $55.8 billion over five years, according to a congressional analysis.

In 1994, conversion factor updates for surgical and nonsurgical services will be reduced, except for the conversion factor for primary care services, which will remain at 6.6 percent. The fee schedule update for surgical services will be reduced from 12.2 percent to 8.6 percent, and for nonsurgical services will drop from 6.6 percent to 4 percent.

Physician fees will also decrease because of a reduction in the relative value units under Medicare's Resource-Based Relative Value Scale fee schedule. Reductions will be phased in for practice expenses for many services. They will apply to all types of services, including anesthesiology and radiology, with certain exceptions, such as those services performed in a physician's office at least 75 percent of the time. The source and justification for these reductions is uncertain, ISMS budget analysts said.

Starting Jan. 1, 1994, the government will repeal the reimbursement ban on EKG interpretations performed in conjunction with office visits and will subsequently unbundle the corresponding RVUs in office visit codes. Also beginning Jan. 1, physicians in their first four years of practice will no longer be reimbursed at reduced rates.

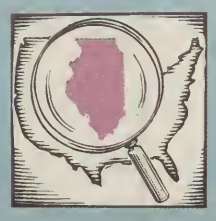
In other provisions, the budgeted 1994 and 1995 fee updates for durable medical equipment will be zero. The budget signed by the president

(Continued on page 15)

INSIDE

Summer blood levels low, but not critical

PAGE 3



DEPARTMENTS

News Briefs.....2
Commentary.....4
Letters.....5
ISMIE Update.....6
Classifieds.....11



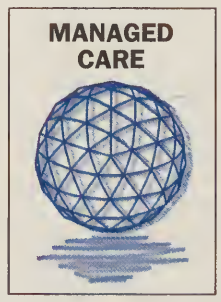
Terry Vitacco

KENNY SEXTON, of Calumet City (right), receives his back-to-school immunizations from Richard W. Biek, MD, a physician with the Cook County Department of Public Health. Children and their parents lined up around the block to receive needed vaccinations free at the department's Aug. 10 immunization drive in South Holland.

Springfield physicians discuss managed care

CHANGE: Physicians who treat state employees meet to discuss the prospect of managed care. By Gina Kimmey

[SPRINGFIELD] When Blue Cross and Blue Shield of Illinois backed out of negotiations with the Illinois Department of Central Management Services, Springfield physicians began pondering the possibility of a managed care plan "takeover" of health care services for state employees. At the July 27 meeting of the Sangamon County Medical Society, John F. Schneider, MD, chairman of the ISMS Third Party Payment Processes Committee and a member of ISMS' ad hoc committee on health care system reform, and Rob Kane, ISMS legal counsel, examined ways physicians can effectively work within a managed care system and provided an overview of antitrust laws.



Right now, Springfield physicians are concerned, said Dr. Schneider. "I don't really have a set of answers. I can't say what you should or shouldn't do, but I hope to stimulate some thinking about managed care and how to deal with it effectively. One needs to think about and learn what's involved and develop a meaningful response." He added that physicians should consider how

(Continued on page 14)

Institute calls for National Vaccine Authority

IMMUNIZATION: The National Institute of Medicine urges increased support for childhood vaccination programs. By Anna Brown

[WASHINGTON] The National Institute of Medicine released a report July 1 that recommends the creation of a National Vaccine Authority as part of a new Children's Vaccine Initiative that would harness new technologies to advance childhood immunization. The NVA would aim to make limited-use vaccines more readily available, according to the report issued by an institute committee.

The NVA could "advance the development, production and procurement of new and improved vaccines of limited commercial potential but of global health need," said Jay P. Sanford, committee chairman and professor of internal medicine at the University of Texas. "If, through the NVA, we could put the strengths of both the private and public sector to work, then the United States could make a major contribution toward disease eradication not only in the developing world, but also within our own inner cities and other disadvantaged segments of the U.S. population."

The NVA would subsidize vaccine purchases by the United Nations International Children's Fund and other health and humanitarian agencies. This would ensure a market and provide higher returns to private vaccine developers and manufacturers, the report said. The NVA would be an opera-

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ISMS member killed

[WILMETTE] Martin R. Sullivan, MD, 68, a Chicago plastic surgeon, was shot and killed in his Wilmette office Aug. 6. At the time of his death, Dr. Sullivan was the chief of plastic surgery at Evanston Hospital, where he had been on staff since 1961. He was also on staff at Resurrection Medical Center in Chicago and was an assistant professor of surgery at Northwestern University Medical School. He maintained offices in Wilmette and Chicago.

Dr. Sullivan was a 33-year ISMS member and a board-certified plastic surgeon. He graduated from the Loyola University Stritch School of Medicine in 1952. A member of the Chicago Medical Society since 1959, Dr. Sullivan served on the society's Fee Mediation Committee and the Physicians' Review Committee. He was a member of several professional organizations, including the American Society of Aesthetic Plastic Surgery. ■

Chicago-area hospitals consider merger

[CHICAGO] Four Chicago-area hospitals are examining the possibility of merging, and each may vote on the issue within the next month, according to one hospital spokesperson. A merger of Northwestern Memorial Hospital and Children's Memorial Hospital in Chicago, Evanston Hospital Corp. and Highland Park Hospital has been planned since the hospitals formed the Northwestern Memorial Health Care Network in October 1989, according to Dan Parker, spokesperson for Northwestern Memorial.

"When the network formed, a merger was part of the plan," Parker said. "We've been in the planning phase since 1989, and we have coalesced since then." The network elected officers in February 1990 and developed its primary goal of creating a "preeminent and integrated health care delivery system for the Chicago metropolitan area and [becoming] a regional referral center for the Midwest."

Parker said he is optimistic the merger will be approved. Other network hospitals, however, were less certain about the potential outcome of the proposed merger. Children's Memorial is in the midst of a "very intense planning and review effort at the board level," said spokesperson Sarah Wilcox. "We're looking at many options to best provide care to children under managed care health care reform." The hospital has not yet completed analyzing the merger proposal, but its board of trustees is expected to vote on merging before November, Wilcox said.

Although Evanston Hospital officials did not return calls for comment, the hospital's medical staff recently voted 200-1 against a merger. A spokesperson for Highland Park Hospital denied that a vote on the merger is planned. ■

Recommendations for Prozac use expanded

[WASHINGTON] A U.S. Food and Drug Administration advisory panel has recommended that the antidepressant Prozac be approved for use in treating obsessive-compulsive disorder. This debilitating medical condition, which commonly begins in childhood or adolescence, is characterized by recurrent unwanted and unpleasant thoughts and/or repetitive, ritualistic behaviors. About 5 million people in the United States suffer from obsessive-compulsive disorder.

Clomipramine hydrochloride, another tricyclic antidepressant, is the only drug currently approved for treating obsessive-compulsive disorder in patients age 10 and older, according to Edwin Cook, MD, assistant professor of psychiatry and pediatrics at the University of Chicago. "The question remains as to whether Prozac or [clomipramine hydrochloride] is more effective," Dr. Cook said. "Once Prozac is approved, one possibility will be to start treatment with it because it is often effective with no significant side effects, whereas [clomipramine hydrochloride] almost always leads to side effects, which are a nuisance to patients."

Dr. Cook said clomipramine hydrochloride causes the typical tricyclic side effects of orthostatic hypotension and sedation. It can also affect cardiac conduction and cause tremor. In one out of five patients, Prozac leads to decreased appetite, insomnia or irritability.

According to a spokesperson for Eli Lilly and Co., manufacturer of Prozac, the company expects FDA approval in the near future, possibly by the end of 1993. ■



ALAN M. ROMAN, MD, public affairs chairman of the American Cancer Society, Illinois Division (left), is honored by Illinois Division Chairman Stanley Tannenbaum for his work in support of the state's newly enacted cigarette tax hike. Dr. Roman received a shoe trophy with a symbolic hole in the sole to show how he pounded the pavement lobbying for the 14-cent-per-pack cigarette tax increase. The American Cancer Society predicts Illinois' new tobacco taxes will stop 6,000 children from smoking. Dr. Roman currently serves as ISMS president-elect; the Society also strongly supported the tobacco taxes.

Nicotine patches may calm ulcerative colitis

[BOSTON] Preliminary study results show that, for unknown reasons, transdermal nicotine patches appear to ease symptoms of ulcerative colitis. The findings were reported in May by researcher Rupert D. Pullan, MD, who conducted the study as a gastroenterology fellow at University Hospital of Wales in the United Kingdom.

Dr. Pullan and associates from three other centers studied 72 otherwise-healthy patients with active left-sided colitis. Thirty-five of the patients wore a transdermal nicotine patch for six weeks; 37 wore identical placebo patches. The patients who received the nicotine showed significant improvement in their clinical grade, stool frequency, mucus presence, urgency and pain. Seventeen of the 35 patients in the nicotine group (49 percent) had complete clinical remissions, compared with only nine of the 37 patients on placebo (24 percent).

The study did not reveal how long colitis patients would have to stay on transdermal nicotine. Some study participants relapsed after they stopped wearing the patch. Others remained in remission. Dr. Pullan, now with the department of surgery at Princess of Wales Hospital, Bridgend, Wales, also said that the mechanism has not been studied extensively. Nicotine might act on the immune system, eicosanoids or colonic mucus. He cautioned that further study is necessary before nicotine patches are recommended for treating these patients.

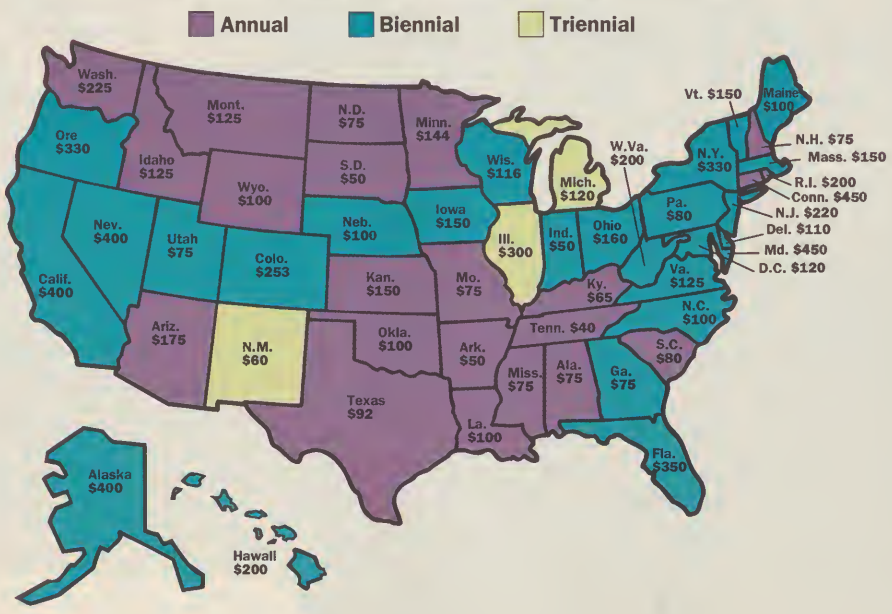
Dr. Pullan said ulcerative colitis seems to primarily affect nonsmokers. Since 1982, data from a United Kingdom study comparing 230 colitis patients with age- and sex-matched controls showed that only 8 percent were current smokers compared with 44 percent of the controls and 39 percent of the general population in the United Kingdom ■

PHYSICIAN FACTS

Renewing a medical license

The frequency for renewal of physicians' medical licenses varies from state to state. Doctors in 22 states must renew annually, while 25 states and the District of Columbia require biennial renewal. Only three states limit renewals to every three years. And the costs vary, too. At $450 a year, Connecticut is most expensive. At $20 a year, New Mexico is least expensive.

What states charge for license renewals (1992-93)



Source: *The Exchange*, a publication of The Federation of State Medical Boards of the U.S.

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Summer blood levels low, but not critical

DONORS SOUGHT: Northern Illinois' LifeSource continues its efforts to increase blood donation in the Chicago area. By Anna Brown

[GLENVIEW] Blood shortages have not been as severe this summer as in past years, according to LifeSource, Illinois' largest blood center. Because of beefed-up telemarketing and slightly lower blood usage, blood supplies in Chicago and six surrounding counties have been in relatively good shape. "We made it through the Fourth of July without the typical dire shortage," said LifeSource spokesperson Pat Grote, but noted that type O and type B blood are still in high demand. Despite having averted a crisis this summer, Chicago still imports 18 percent to 20 percent of its blood from other parts of the state and other states.

"Chicago always has a shortage," Grote said. "We're on pins and needles until the end of summer. We're never able to completely meet the need." The donation rate in Chicago is 3 percent, she said. "Some communities have 5, 6 and 7 percent of the population donating on a regular basis."

The period around Labor Day is the worst for blood donation, Grote explained. In the summer, prime donor sources such as high schools and colleges suspend blood collection. That lack of donation has a cumulative effect that can be compounded by the holiday. Sometimes no one donates at all over that weekend, she said. To combat the lag, LifeSource hosted a three-day "phone-a-thon," beginning Aug. 19, targeting the 300,000 previous donors in its data base. The program, dubbed "dialing for donors," was intended to increase the number of summer donors and recruiters.

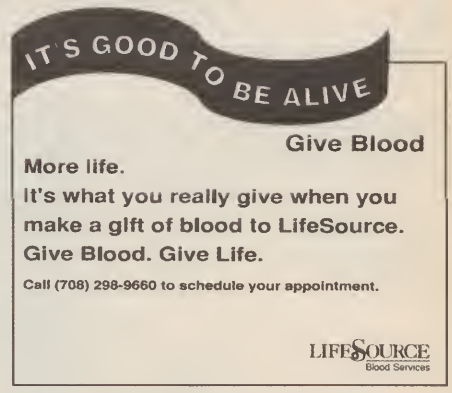
The theme for this year's donor recruitment campaign is "It's good to be alive," which LifeSource has promoted through posters and public service advertising. LifeSource operates 14 blood centers, four in the city and 10 in the suburbs. The newest center is a corporate blood collection facility in the Deerfield headquarters of the health care conglomerate Baxter International. The facility is exclusively for Baxter employees and is open three days a week. Some of the other centers are open seven days a week, from morning to late evening, Grote said.

"We're constantly trying to bring more donors in," she said, but noted that donation levels seem to be improving a little from previous years. The percentage of the LifeSource donor base that donates only once a year has decreased from 80 percent in 1987 to between 65 and 70 percent in 1991, indicating that those who donate are doing so more frequently. Currently, 20 percent of donors donate twice a year. Healthy individuals can donate whole blood every 56 days, or about six times a year, Grote said.

Physicians can help increase blood supplies by encouraging healthy patients to donate, Grote said. "It's in physicians' best interest to help ensure that we have a safe and adequate blood supply."

Patients who participate in autologous donation can be certain of safe blood for scheduled surgeries. "There is no safer blood than your own," Grote said. LifeSource does not recommend directed donations from friends or relatives. Recent studies have shown that directed donations are no safer than homologous ones. Grote explained that when some individuals are asked to donate blood for someone they know, they feel pressure to do so, even if they know that medically they should not.

ISMS encourages its component societies to promote public acceptance of "truly altruistic blood donation and community responsibility." ISMS policy states, "Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county." In addition, the Society attempts to educate physicians and their patients that individuals cannot contract AIDS by donating blood. ■



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REPORT FOR *Illinois Physicians*

LENGTH OF STAY (LOS) FOR NORMAL VAGINAL DELIVERY AND UNCOMPLICATED C-SECTION

As another step to encourage the provision of high quality cost-effective health care to its enrollees, Blue Cross and Blue Shield of Illinois is going to implement new utilization standards for obstetric care as of September 1, 1993.

The new standards will indicate that the hospital lengths of stay for the mother following delivery should be **24 hours** for **normal vaginal delivery** and **72 hours** for **uncomplicated C-Sections**. Both the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics have indicated that these lengths of stay are reasonable in appropriate circumstances *. Many HMOs and other health insurance carriers have already implemented obstetrical discharge programs based on these lengths of stay.

There are many advantages to these shorter lengths of stay:

- Rapid return of mother and infant to the natural home environment, which should facilitate "bonding" and even breast feeding.
- Less exposure to nosocomial infections.
- Enhancing the concept for patients that childbirth is essentially a normal physiologic process.
- Effective and efficient use of health care resources.

Effective September 1, 1993, Blue Cross and Blue Shield of Illinois will approve for the mother, a post-delivery 24 hour LOS for normal vaginal deliveries, and a post-delivery 72 hours LOS for uncomplicated C-Sections. Of course, if the attending physician indicates that some sort of complication or other problem is present, additional days of hospitalization, as are medically necessary, will be approved to appropriately handle these complications.

* "Guidelines for Perinatal Care", 3rd Edition, 1992.

(Issue: 08/27/93 - ALW)

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EDITORIAL

Stopping the violence against physicians

As the medical community knows by now, Martin Sullivan, MD, was shot Aug. 6 in his office in Wilmette. He was killed by a white supremacist, posing as a patient, who targeted Dr. Sullivan because the plastic surgeon was allegedly "feeding off Aryan beauty" by reconstructing facial features. The loss of any human life is a tragedy, but this murder was especially reprehensible. Dr. Sullivan, the chief of plastic surgery at Evanston Hospital, operated mostly on accident victims and women recovering from breast cancer. He also performed surgery on needy patients – for instance, children with congenital defects. He was a husband and father, and a colleague to many Illinois physicians.

Why does such violence occur in what were once safe settings, like hospitals and other places of healing? In May, a Rockford urologist was stabbed in a clinic by a patient. The attacker's family said he had a history of violent behavior.

Easy access to guns facilitates violence. Deaths from handguns are significantly higher in the United States than in other developed countries that enforce strict gun control laws, according to Willard Fry, MD, a member of the board of directors of the Illinois Council Against Handgun Violence. The council supports the Brady bill, a federal proposal calling for a five-day waiting period before individuals can buy a gun. It is far too easy for people who should not own guns, to purchase and use them very quickly. That, coupled with the fact that health care providers see unknown patients in their offices and in hospital emergency rooms, creates potentially volatile situations. Assaults per hospital doubled from 1987 to 1989, according to a survey by the Lombard-based International Association for Healthcare Security and Safety.

Drive-by shootings and recent episodes of violence mixed with greed – such as the killing of James Jordan – show how desensitized to violence we have become. Perhaps part of the reason is the proliferation of guns and violence in television and the movies.

Medical researchers have not escaped violent intolerance either. This year, a geneticist from San Francisco and a Yale University professor were seriously injured by mail bombs. In response, the AMA demanded an investigation into those individuals and groups known to target physicians and researchers in their offices and labs. The AMA also called for congressional hearings on violence against health care workers and the drafting and enactment of a "health care protection act."

In today's society, some people feel entitled to harm or kill others who do not share their ideologies. It is ironic that a country founded on the premise of freedom and tolerance for all has "evolved" to a level of extreme intolerance.

PRESIDENT'S LETTER

A single-payer system may not be dead

By Arthur R. Traugott, MD



A single-payer system makes no more sense at the state level than it does at the national level.

If you thought the prospect of a single-payer system was dead, think again. According to recent news stories, the system still has enough proponents to be a national reform option for individual states. A story in the *Chicago Tribune* says that 86 congressional Democrats are on record as favoring a single-payer plan. The list includes Illinois Reps. Cardiss Collins, Sidney Yates, Luis Gutierrez, Bobby Rush, Mel Reynolds and Lane Evans. According to the story, "Officials believe these Democrats will come around once they see that President Clinton's plan will be flexible enough to allow individual states to adopt a single-payer system."

In addition to individual proponents, certain groups, such as the Neighbor to Neighbor organization, have actively lobbied for the single-payer plan. In early August, the Physicians for a National Health Program released results of its study of the U.S. health care payment system. PNHP has been using those findings as a springboard to push a single-payer system as an antidote to health care bureaucracy.

Yet, according to a story in *The Wall Street Journal*, the Canadian health care system – often cited as the prime example of a single-payer system – has the problem of escalating costs that "have added substantially to Canada's staggering national debt." Those costs have distorted health care delivery and access. A recent study published in the *New England Journal of Medicine* reported that nearly one-third of Canada's doctors have sent patients outside the country for treatment during the past five years.

The Wall Street Journal story maintains that even when advanced equipment is available, "bureaucratic absurdities prevent proper use." The story cites the example of York Central Hospital in metropolitan Toronto, where dogs were able to get CAT scans immediately, but humans were placed on a waiting list. Canadian patients cannot pay for CAT scans. Operating the equipment is so expensive that it can be used for only a few hours a day by nonpaying customers. Dog owners, however, were permitted to pay to use it. The solution seemed obvious. But instead of allowing humans to pay, the Canadian government banned the use of CAT scans for dogs.

Providing "free" medical care to all Illinois citizens through a single-payer system is unrealistic. Although such plans propose universal access to care, what they actually result in is rationing, because they do not address the causes of increasing health care costs. The cost of providing comprehensive care through government has resulted in a reduction of services in Canada. The solution of increasing taxes remains most unpopular in America. That is why we continue to argue that a single-payer system will result in more extreme rationing of services.

Again, Canada is a perfect example of the impact of limited funds on the delivery of medical care. Patients have to wait, on average, five weeks to see a specialist, according to a 1992 study by the Vancouver-based Fraser Institute. Some patients waited as long as 14 weeks for surgery.

A government-run, single-payer system would eliminate private health insurance, which currently covers more than 7 million Illinois citizens. Instead, ISMS advocates changing current insurance practices. ISMS wants to eliminate risk rating and discrimination based on pre-existing conditions. Risk pools should be expanded. Self-insured and small employers should have the same tax advantages as the large corporations.

A single-payer system makes no more sense at the state level than it does at the national level. *The Wall Street Journal* article clearly identifies the serious flaws and shortcomings of the Canadian system. ISMS stands for health care system reform. We cannot afford a major disaster for the people of this country. Let's see that we truly do reform our health care system.



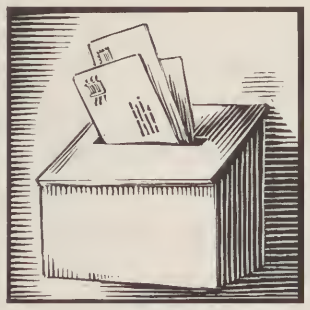
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LETTERS

More clinic support

The physicians of Sangamon and Menard County medical societies are very proud of our new free clinic. We also appreciate your Aug. 13 story about how the clinic came to be.

It is important to us that your readers know of the generous support the clinic has received from two hospitals in Sangamon County. In addition to the $25,000 contribution by Springfield's Memorial Center Medical Foundation, which was reported in your story, St. John's Hospital in Springfield also donated $25,000. Our clinic would not have been possible without these two large contributions.



We welcome all corporate support, but generous contributions from our hospitals show a united front from our health care professionals. Medical professionals throughout Illinois should know that hospitals and physicians stand ready to do their part to provide high-quality medical care to those who are not covered through insurance or government programs.

The Healthfirst Community Clinic, located at First Presbyterian Church in Springfield, will treat low-income residents in Sangamon and Menard counties who do not qualify for Medicaid or public aid. About 150 physicians have indicated they are willing to volunteer.

As ISMS Fifth District trustee and Sangamon County Medical Society president, I salute the efforts of both these medical institutions in Sangamon County in helping us get this clinic off to a successful beginning. On behalf of the physicians in and around Springfield, I deeply appreciate their very meaningful assistance.

Jane L. Jackman, MD
Springfield

ISMIE survey to monitor claims service satisfaction

As part of its ongoing effort to provide exceptional service to each policyholder-owner, ISMIE has developed a series of three surveys to measure policyholder satisfaction with the claims-management process. If you are facing a malpractice claim, you can expect to receive brief questionnaires from the Exchange. The surveys include questions about your satisfaction with the ISMIE representative and defense counsel handling your case.

ISMIE recognizes that physician involvement in medical malpractice actions is often difficult and frustrating. But your feedback is critical to help the Exchange meet your needs. Using the survey results, ISMIE can take appropriate physician-directed action to hone its claims-management process. If you have questions about the surveys, contact ISMIE at (800) 782-ISMS or (312) 782-1654. ■

GUEST EDITORIAL

A tribute to difficult decisions

By Barbara Hasko Curry, MD

It was a gloomy day – dreary, sullen – in contrast to the previous night's Independence Day celebration. There was sadness in the department, too; everyone had seen the news splashed across the morning paper. Her body had been found. I doubt there was anyone who was not affected by this tragedy. When one of the nurses told me that her mother was here, I didn't have to ask whose mother it was.

I'd known before I saw the paper, anyway. Yet I'd been watching the news, as had so many others, hoping against hope that she would be found alive. She was only 10 years old, and she was a beautiful child – lustrous dark hair, twinkling mischievous eyes, and that captivating smile. I never knew her, but her picture was in the media. I can see it still. She had left a friend's house to go home for supper, riding her bicycle. It was a pink bicycle, like so many little girls have. Her friend even rode halfway home with her. She never made it the rest of the way. Her dad found her bicycle, an hour or so later, leaning on its kickstand a few blocks from home. She was found two days later, on the Fourth of July.

It wasn't simply that she was a pretty girl, or that it happened within a mile of our house, or even that it was any parent's worst nightmare. What really got to me, even before I met her mother, was the intensity of this family's turmoil played out so vividly in the media. All along I had been asking myself, how does one survive this kind of tragedy? Each minute must seem like an eternity of pain. How do they continue?

When the nurse informed me that the girl's mother had just been brought into the emergency department, I was both curious and terrified. I wanted to see her, to know how she was able to survive so horrible a thing, as reassurance that if something as horrible ever happened to me, I might be able to survive it, too. But I was afraid to see her pain. My anguished expression must have prompted the nurse to ask if she should find the other doctor on duty to see the patient instead. But I told her I could handle it. I picked up her chart, prayed that I wouldn't cry, and went into the room.

The chart listed the chief complaint as "unable to sleep." I don't know what I expected. Hysteria? Screaming? Pounding on the walls? Previously, I had given bad news to people who were not expecting it. But this lady was calm, and she looked me straight in the eye and said, "Doctor, I am not sick. You know that, don't you? I am not sick. My heart is broken." I stood in silence before her. I knew there was nothing in my black bag for this woman. All the sophisticated technology and state-of-the-art pharmacotherapeutics at my disposal were for naught in the face of this simple devastation. Totally unequipped by years of training and experience, I could only cry.

We get conditioned in this business to believe that we are not supposed to cry around patients. And, in general, I suppose this is a good rule of thumb. With all the tragedy, we would be crying all the time if we allowed our feelings to take hold. However, I would wager that in every clinician's career there has been a time or two when circumstances made it impossible to hold back emotion. I also now believe there are times when shared emotion between physician and patient is the best, if not the only, effective treatment.

So I cried. We cried. We held each other and cried. She told me about her daughter's fine embroidery, and I told her about my little girl, too. We talked about her guilt, and her anger, and her despair. But mostly we cried. And then her husband came in, and we all held each other and cried some more. And I knew then how this family would make it from minute to minute and from hour to hour. They would survive by spreading out their tremendous burden of grief to people who, like me, would be willing to share small parts of it, moments at a time, over weeks and months, maybe years, until the burden would become manageable. And I knew for that moment, I had given this patient the treatment that she needed.

It has been four years now. I have never seen this family again. They invited me to stop by their home as they left the emergency department that day, but I never could go – it was too painful. But I think of them often, and in some small way just writing this serves as catharsis.

Some have said that I should have avoided this encounter altogether or handled it some other way. In truth, I paid a price for treating this woman with my tears. In giving her the opportunity to grieve openly with me, I assumed a small portion of that grief myself. But I am not sorry. I am first a human being and only second a doctor, and the two are not mutually exclusive. And so, as I reflect on this experience I realize that I, too, am grieving – for a child I never knew, for a family that touched my heart. And as Independence Day rolls around again, I know that I will always remember.

Dr. Curry practices at Deaconess Medical Center in Billings, Mont.

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ISMIE Update

Exchange surveys to monitor claims service satisfaction

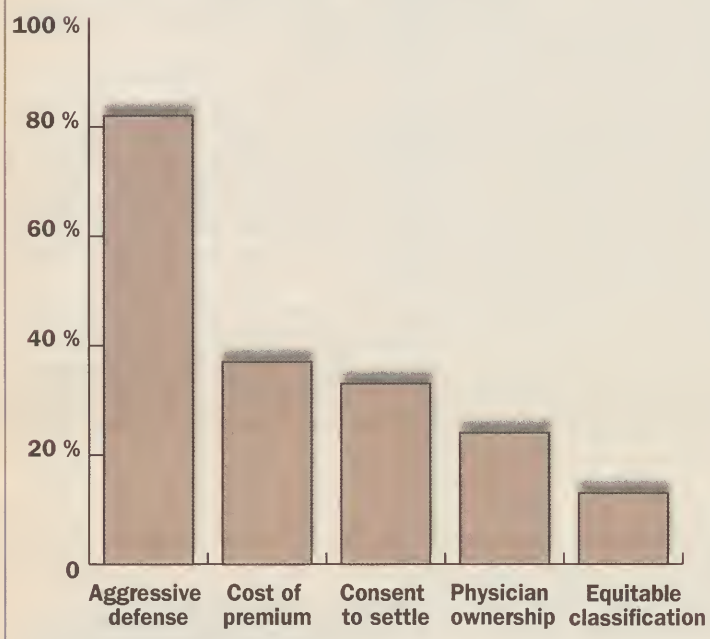
PAGE 5

Risk management messages on the way

PAGE 7

Important components of a liability insurance program

ISMIE policyholders were asked to choose which two of the following features were most important in a professional liability program.



Source: ISMIE Policyholder Survey
February 1993

Case in Point

Follow-up and documentation minimize physician liability

By Kathleen Furore

Presenting complaint and initial diagnosis: A 36-year-old female with a history of mitral valve replacement visited an internist for what appeared to be a common cold. The physician diagnosed acute bronchitis, prescribed antibiotics and cough medicine, and ordered a chest X-ray, which showed severe mitral valvular disease and congestive heart failure.

During a routine visit five months later, the internist – who had not seen the initial X-ray report and therefore had not followed up on its findings – detected an irregular heartbeat. When the patient mentioned that her cardiac surgeon had diagnosed atrial fibrillation two years before, the doctor ordered an EKG and chest X-rays. After the EKG confirmed atrial fibrillation, he prescribed digoxin and instructed the patient to return in three weeks. But two days later, when the physician saw that the chest X-ray report revealed pulmonary edema, he became concerned and phoned his patient to tell her about the edema and refer her to a cardiologist. However, he was unable to reach her and failed to document his phone calls in the chart.



When the patient failed to report for the three-week follow-up visit, a staff member phoned her to reschedule the appointment. Again, the patient was not reached, and the attempted contact was not documented.

The case in brief: Two months after the patient's last office visit, she returned complaining of loss of vision in her right eye. The internist referred her to an ophthalmologist, who admitted her to the hospital and diagnosed retinal artery embolus.

The resulting claim: The patient sued the internist, maintaining that the retinal artery

MALPRACTICE ROUNDUP

Woman wins 'fear of AIDS' suit

Hospital Risk Management reports a Tennessee Court of Appeals ruling that a hospital visitor need demonstrate only the reasonableness of his or her fear of contracting a deadly disease such as AIDS to recover on a claim for emotional distress. While visiting her sister at a Tennessee hospital, the plaintiff reached for a box containing what she thought were paper towels, but were instead used needles. She received three needle pricks.

The woman filed suit against the hospital, alleging intentional infliction of emotional distress. Her claim was based on her fear of contracting AIDS from the needle-stick exposure. The hospital's motion for summary judgment was granted at the trial court level, based on the plaintiff's failure to factually show exposure to the AIDS virus. However, the appeals court ruled that the plaintiff was not required to demonstrate that she had actually been exposed to the AIDS virus, because the standard was the reasonableness of her fear of contracting the virus. The plaintiff presented evidence that the medical profession presumes the AIDS virus can be acquired through sticks from contaminated needles, leaving the court to determine only whether the plaintiff's fear was reasonable. ■

Immunity for peer review

A Wisconsin appellate court has found in favor of three doctors accused of "tortious interference and conspiracy" for their evaluations in a peer review. As outlined in the *Malpractice Reporter*, a clinic's quality assurance director reviewed 22 patient files of a surgeon whose referrals had sharply declined. The director, also a surgeon, asked two other physicians at the clinic to review the files and give their opinions as to whether the cases had been handled appropriately. He later presented concerns about the surgeon to the executive committee.

The physician subsequently resigned, claiming he was told that the reviewing physicians had lost confidence in him and that he should leave the clinic. The surgeon further maintained that he hadn't been allowed to explain the cases. He filed suit against the quality assurance director and the reviewing physicians, alleging they had destroyed his reputation. The three physicians claimed immunity because their review was part of a peer review process.

The plaintiff argued that for immunity to be granted, a review of health care providers must be conducted as part of an organized program. He claimed he was subjected to an ad hoc investigation with no record requirements and no opportunity to defend himself. The court disagreed, maintaining that because the evaluations were requested by the quality assurance director, not just another colleague, the reviewing doctors believed they were participating in a valid peer review procedure. They were therefore entitled to the presumption of good faith and immunity from liability. ■

Breast cancer diagnosis suits increasing

Evidence that early detection of breast cancer can save lives has led to an increasing number of lawsuits by women who allege that their physicians failed to diagnose the disease early enough. Settlements have ranged from $50,000 to $2 million. In the past, defendants maintained that the patient would have died with or without an early diagnosis. But, as reported in *Business Insurance*, treatment advances make that defense tougher to prove. Plaintiffs can, however, claim that if breast cancer had been detected earlier, disfiguring mastectomies could have been avoided.

Many diagnosis suits turn on whether the physician should have been more vigilant in investigating a breast lump. In some cases, plaintiffs can prove that physicians violated breast cancer screening guidelines endorsed by various medical organizations. Physician record keeping can make or break a case, say lawyers, because the timing of the first report of symptoms is often disputed. ■

embolus and resulting loss of vision in her right eye could have been prevented if anticoagulants had been prescribed for her atrial fibrillation. She also sued for his alleged failures to take an adequate history, to follow up on the initial chest X-ray, to inform her of the results of the second chest X-ray and to refer her to a cardiologist.

The outcome of the claim: The case was settled for $300,000 for the internist and $300,000 for his group.

The points this case makes: Although follow-up calls and documentation are not necessarily standard-of-care issues, they are absolutely essential from a risk management perspective, according to Timothy Nickels, a partner in the Chicago law firm Wildman, Harrold, Allen & Dixon and a defense attorney in professional liability cases for the Exchange.

Standard of care doesn't require you to write a book, but comprehensive, contemporaneous notes are the best witness a doctor can have.

"Keeping thorough, legible records and maintaining good doctor-patient communication are the most important things doctors can do to minimize risk," Nickels said. He noted that the internist's most serious errors were failing to review and follow up on the initial chest X-ray, failing to document his attempt to phone the patient about the results of her second X-ray and failing to use a system for staff documentation of patient follow-ups and rescheduling.

"Standard of care doesn't require you to write a book, but comprehensive, contemporaneous notes are the best witness a doctor can have. They're a witness whose memory never dies," Nickels continued. "If a doctor says, 'I called,' but didn't notate it, the call didn't happen as far as a jury is concerned. But if there are notes in the chart, they could blow the plaintiff's case away. An attorney might even be discouraged from filing a case if he or she sees the doctor has notes and maybe even a copy of a letter or reminder card sent to the patient. Those things indicate a careful doctor, and an attorney knows he or she would have to overcome the notes and the letter."

Henry Martin-del-Campo, MD, a faculty member in the family practice residency program at the University of Illinois, agreed with Nickels and emphasized the lack of documentation.

"Most patients with a history of mitral valve replacement are already on sodium warfarin or anticoagulant therapy," said Dr. Martin-del-Campo, a member of ISMIE's Risk Management Family Practice Subcommittee. "The fact that this patient wasn't [on such therapy] should have been addressed in the internist's notes. If he had written that the patient was transferred without medications, it would have supported his case. The next thing is the lack of documentation about the phone calls. His credibility is immediately challenged if he has to go in front of a jury. If the results of the X-rays were so important that he tried to get in touch with the patient several times, then it should have been important enough to document."

Dr. Martin-del-Campo added, however, that physicians should never try to change or add to a patient's records after a suit has been filed. "Many people don't realize that it's very easy to date ink. And it can be extremely helpful [to the plaintiff's case] if an attorney can prove you wrote something after you were subpoenaed. Once he or she has done that, your credibility is gone, and you've lost the case. And you may even be suspect to your insurance company; it may not want to continue carrying you."

It is, of course, difficult for doctors to continually monitor every patient's chart to ensure every test report has been seen, every diagnosis reported and every appointment kept or rescheduled. But as Nickels and Dr. Martin-del-Campo emphasized, follow-up and documentation procedures are indispensable in practicing safe, defensive medicine and providing optimal patient care.

To achieve that goal, Nickels and Dr. Martin-del-Campo offered the following advice:

• Create an internal tickler system – independent of the patient's chart – that lists what tests were ordered for each patient, when the tests were ordered, when the results were reviewed and when the results were communicated to the patient.

Dr. Martin-del-Campo said he receives a printout listing all the patients he sees each day. He writes notes such as "check MRI" or "check EKG" on the printout and reviews it weekly.

• Instruct your office staff about the importance of follow-up and documentation, and establish a system to facilitate follow-up and documentation procedures. Consider sending letters and/or reminder cards to your patients about scheduled or missed appointments and keep copies of the correspondence in the patients' charts. All phone calls – regardless of whether you or your staff actually reached the patient – should be noted in patients' charts.

• Always keep a visible history of each patient's chronic and acute problems and what Dr. Martin-del-Campo calls "complete SOAP dictation," so that anyone looking at the patient's chart would know where you've been and where you're going with that patient. SOAP stands for subjective (patient's complaints); objective (your findings); assessment (your diagnosis); and plan (what you told the patient, what you prescribed and what you plan to do in the future). ■

"Case in Point" is a regular feature using hypothetical case histories to illustrate loss-prevention maxims.

Risk management messages on the way

One of ISMIE's primary goals is providing its policyholders with information to improve quality of care and limit liability exposure. To help achieve that goal, the Exchange recently sent policyholders a risk management brochure detailing ways office staff members can minimize situations that may cause patient dissatisfaction and maximize those events that promote quality care. The brochure covers communication, documentation and office procedures such as follow-up, billing and collection, and termination of services.

ISMIE is also sending a new series of risk management brochures to primary care physicians. Based on recommendations of the Exchange's Risk Management Family Practice Subcommittee, the brochures address potential liability risks associated with providing primary care. Topics include evaluating patients who experience persistent symptoms, following cancer screening guidelines, establishing effective follow-up systems, and documenting evaluation and treatment of patients with continuing complaints.

For more information about these publications or risk management topics in general, contact the ISMIE risk management department at (800) 782-ISMS or (312) 782-1654. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

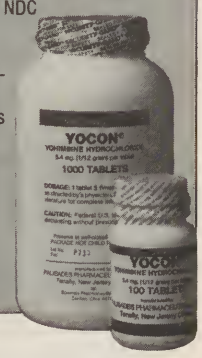
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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PROGRAMS TO HELP THE INDIGENT

Filling prescriptions for the needy

Pharmaceutical companies offer programs that make payment for prescription drugs easy to swallow.

BY KATHLEEN FURORE

In Florida, an elderly woman receives free from Searle a medication she could barely afford on her meager retirement income. "It's difficult to be old and poor, with a much lower standard of living than you had when you were young and able to work," she wrote to Searle. "You've been a big help."

In North Carolina, a 57-year-old patient – "financially wiped out" after three cardiac arrests – takes free medications from Searle and calls the company's generosity a "godsend."

In flood-ravaged southern Illinois, physicians and patients request free Ciba-Geigy medications to replace their prescription drugs lost or damaged in the natural disaster.

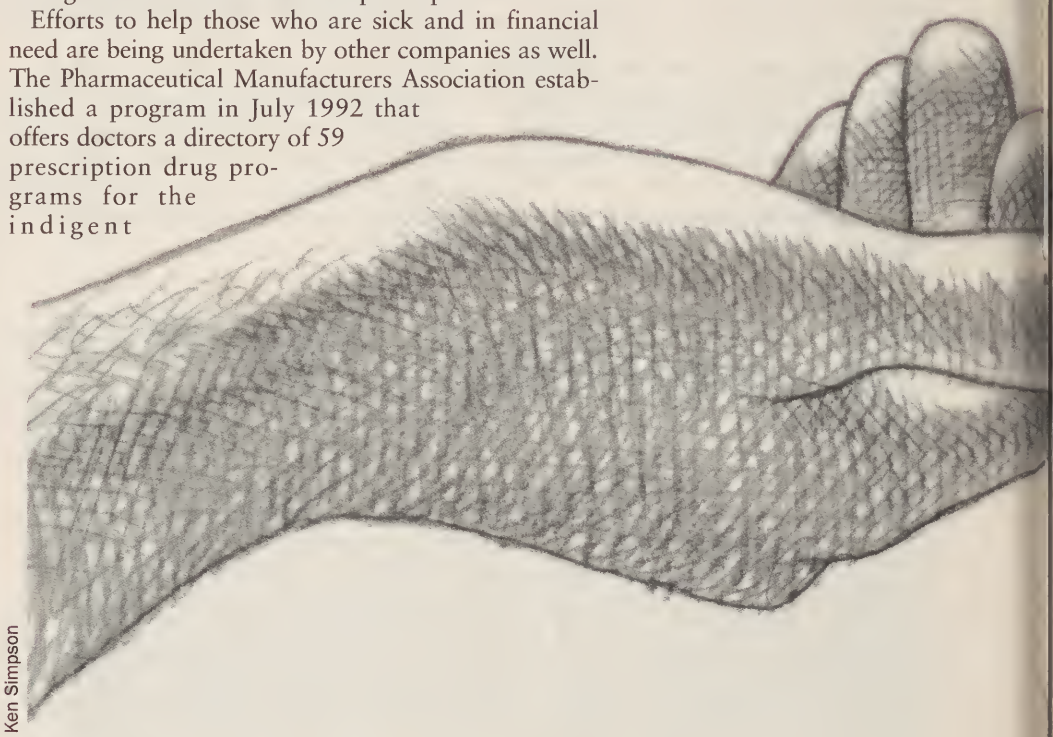
Throughout Illinois, patients enrolled in smoking-cessation programs request free nicotine transdermal patches, recently donated to the state by Lederle Laboratories.

These are just four examples of the myriad ways pharmaceutical companies are helping needy patients nationwide to obtain medications they could not afford if forced to buy them on their own. And they illustrate the important role corporate programs for the indigent play in ensuring patient compliance with doctors' orders.

"We're trying to close the loop for those who fall through the cracks of Medicare, Medicaid, employee assistance plans and traditional medical coverage," explained Pam Rasmussen, a spokesperson for Searle's Patients in Need program. "We realize that when you're struggling, any expense can be difficult. Even $15 for medication is a lot for some."

That opinion was echoed by the spokesperson for Ciba-Geigy's Patient Support program, which provides physicians with free medications for indigent patients and is independent of the company's current aid to flood victims. "There are a lot of people who have to make a decision between buying medicine and buying food," said spokesperson Karen Rothweiler. "The Patient Support program is our attempt to get rid of that decision. We're trying to fight things like people taking half-doses to stretch their prescriptions."

Efforts to help those who are sick and in financial need are being undertaken by other companies as well. The Pharmaceutical Manufacturers Association established a program in July 1992 that offers doctors a directory of 59 prescription drug programs for the indigent



Ken Simpson

PROGRAMS TO HELP THE INDIGENT



sponsored by 44 PMA member companies. The program includes a toll-free PMA hot line – (800) PMA-INFO – physicians may call for up-to-date information on drugs available to those in need.

According to Steve Berchem, assistant vice president of communications for PMA, statistics show that doctors are interested in programs to help needy patients. "This July alone, we received 1,700 written requests and 3,000 calls from physicians," he said, noting that from July 1992 to May 1993, participating companies received almost 250,000 requests for free medications.

Berchem emphasized, however, that although the demand for free prescription medications has increased since the program was initiated, companies have been informally donating drugs for years. "The pharmaceutical industry has a long tradition of providing free medications to physicians for their needy patients. This program merely formalized and expanded their efforts."

EACH FREE PRESCRIPTION drug program has its own procedural guidelines for physicians to follow and eligibility requirements for patients. For example, guidelines for Searle's program recommend that doctors request free medications for patients who do not qualify for outpatient prescription drugs under private insurance, a public program or other assistance that pays completely or partially for the medications. They also suggest that income be $10,000 or less for households of one or two people, $15,000 or less for households of three to five people, and $24,000 or less for households of six or more people.

Despite the recommendations, Rasmussen said the program – which now includes 10 Searle medications – leaves patient eligibility entirely up to the physician and requires no paperwork or formal documentation for eligibility. Some programs, however, require doctors to submit documentation confirming the patient's income, medical needs, and so on. Some companies provide free medications on a case-by-case basis.

After enrolling in the Searle program, physicians receive an initial supply of certificates, redeemable only at pharmacies, for free prescription drugs. Before giving the certificates to patients, doctors must indicate on the form that the patient meets the enrollment criteria and note the prescribed products and dosages. Since the program's inception in 1987, about 1.3 million certificates valued at $44 million have been redeemed, according to Rasmussen.

Ciba-Geigy's Disaster Assistance policy, currently in effect in Illinois, enables doctors and patients to replace the portion of Ciba-Geigy merchandise lost in the flood that is not covered by insurance. To replace products or receive credits, physicians need only supply certain information, said C. William Howe, government relations manager of the company's Midwest region. Documentation should include a copy of the proof-of-loss statement provided by insurance companies; a list of the Ciba, Geigy, Summit or Basel pharmaceutical products destroyed; and either a list of replacement products or, if doctors prefer credit, the name and location of physicians' wholesale dealers.

To receive the free ProStep nicotine transdermal patches donated to various county health departments, hospitals and agencies in Illinois, patients must prove that they are over 18 and that they participate in a formal, comprehensive smoking-cessation program. The patches are being distributed to local agencies through the Illinois Department of Public Health.

"Local health departments and other local health agencies across the state were given the opportunity to request the patches," said IDPH Director John R. Lumpkin, MD. "This program will be a success if it helps even a handful of people quit smoking."

IDPH spokesperson Karen Grueter stressed that the patches are available only with a doctor's prescription and that those who are ineligible to receive patches include pregnant women, nursing mothers, smokeless-tobacco users, people who smoke less than one pack a day, individuals at medical risk and those who weigh less than 100 pounds.

The Illinois Department of Alcohol and Substance Abuse is also participating in the program by giving patches to community-based substance abuse treatment providers. And the Illinois Department of Mental Health and Developmental Disabilities is starting a pilot program using the patches at a state facility. ■

Going to the source

For additional information about the free prescription medication programs outlined in the story, physicians may contact

- *Ciba-Geigy Disaster Assistance policy.* To receive free replacement drugs or credit, send required information to Gail Sulla, Trade Relations, Ciba-Geigy Corp., Pharmaceuticals Division, 556 Morris Ave., Summit, NJ 07901; or phone (800) 842-2422.
- *Ciba-Geigy Patient Support program.* Direct requests to Jackie Laguardia, program administrator, at the Ciba-Geigy address listed above; or phone (800) 257-3273 or (908) 277-5849.
- *Lederle ProStep patch program*, administered by the Illinois Department of Public Health. To request patches, contact your local health department.
- *Pharmaceutical Manufacturers Association.* For a directory of the 59 corporate programs available from PMA members, write to PMA at 1100 15th St., NW, Washington, DC 20005; or phone (800) 726-7504
- *Searle Patients in Need Foundation.* For enrollment information, write to Searle at P.O. Box 5110, Chicago, IL 60680; or phone (800) 542-2526.

Vaccine

(Continued from page 1)

tional organization within the U.S. government that could reduce the risks and costs associated with vaccine research and development. It would help set priorities for vaccine development in the United States, assemble intellectual property rights, support clinical trials and field testing of promising vaccines, and represent the country in international Children's Vaccine Initiative forums.

The expense of a national vaccine program must be weighed against its long-term benefits, Sanford said. "Eliminating smallpox in the world saved the United States an estimated $120 million annually. Some critics may argue that investing additional funds in new vaccine development, however reasonable, is not feasible in a time of real budgetary constraints. Yet we are a global community, and viruses and emerging infections do not respect borders or boundaries. The United States cannot afford to be parochial in its approaches to infectious diseases, nor in its vigilance to vaccinate against important childhood diseases both here and abroad."

The Children's Vaccine Initiative study, co-sponsored by the U.S. Agency for International Development and the U.S. Public Health Service, revealed that the incentive to develop vaccines in the United States is usually commercial. However, many potentially useful vaccines target only small populations, so companies are often reluctant to invest research and development monies in products that might yield uncertain financial returns, the study said.

According to institute statistics, vaccines are among the most affordable and effective health interventions available. Yet fewer than half of U.S. children under age 2 receive all recommended vaccinations. "We are among the countries with the lowest rates in the world of immunization of young children," Sanford said, noting that financial support for immunization worldwide has not kept pace with increasing costs and demand for immunizations.

"The nation's approach to supporting the development of essential vaccines has been scattershot at best," said U.S. Sen. Edward M. Kennedy (D-Mass.), author of the Comprehensive Childhood Immunization Act of 1993. "Millions of children across the world lose their lives to vaccine-preventable disease. The Institute of Medicine report challenges us to bring new thinking and a new commitment to children in developing stable vaccines against common childhood illnesses." ■

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Free immunizations available in Illinois



The Illinois Department of Public Health offers ongoing child immunization programs at 154 sites statewide. The programs are operated through local health departments and agencies such as visiting nurses associations. Some counties establish school-based clinics. Providers offer a wide range of vaccines, including diphtheria, pertussis and tetanus (DPT), polio, Haemophilus influenzae type B (HiB), and measles, mumps and rubella (MMR). Hepatitis B vaccine may also be offered to infants.

"We receive and distribute vaccine supplies – except MMR – from the [U.S. Centers for Disease Control and Prevention] as a condition of receiving federal funds," said IDPH spokesperson Dawn Edwards. "We're not allowed to charge; however, local health departments can charge a service fee of around $5. But patients can't be refused if they can't pay." The Illinois legislature appropriates funds for the MMR vaccines, she said.

Sixty percent of Illinois children receive their immunizations from public providers, Edwards said. "Anyone can go to these facilities, but many people still go to their personal practitioners."

ISMS policy on immunization states: "Illinois residents should be provided access to all medically indicated immunization." The Society "continues to support the need for physical examinations and updating of immunizations for schoolchildren in the state of Illinois on school entry ... in keeping with preventive medicine measures presently in existence in the state."

– Anna Brown

Send ad copy with payment to Sean McMahan, *Illinois Medicine*, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602; (312) 782-1654, (800) 782-ISMS; fax (312) 782-2023. *Illinois Medicine* will be published every other Tuesday; ad deadlines are four weeks prior to the issue requested. Although the Illinois State Medical Society believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify advertisements at its discretion.

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Managed care

(Continued from page 1)

they can best continue providing high-quality care.

With several large employers – the largest being the state government – a nearby university and a large population, Springfield is an ideal environment for a managed care plan, said Dr. Schneider. Physicians in the area need to know how managed care will affect their practice and their patients. "When a managed care plan is successful, it allows physicians to reassume care of their patients without many of the administrative hassles," he said.

HE OUTLINED two types of plans. One is the "group practice without walls," which involves solo practitioners and small group practices that maintain their own offices but form a corporation that may adopt a uniform fee schedule. This plan centralizes management and reduces administrative costs. In addition, as a separate management entity, it can create ancillary entities, allowing for a broader range of services without generating self-referral problems.

"The hitch here is that you have to find a group of doctors who will compromise and be willing to use the ancillary services, and not refer outside of the corporation," said Dr. Schneider. "There is also a question of liability. Is the corporation liable for the actions of each doctor?"

The second type of plan discussed – a physician-hospital organization, or PHO – is a collaboration between a group of physicians and a hospital. "The most important issue here is that the PHO must be owned and controlled equally between the hospital and the doctors," said Dr. Schneider. The hospital handles the billing and administrative issues, while the doctors control and are responsible for all clinical decisions.



Ron Ackerman

During a July 27 presentation, Dr. Schneider told Sangamon County Medical Society members that many managed care plans require their enrolled physicians to be board certified and committed to using resources prudently.

Many managed care plans require enrolled physicians to be board certified and committed to using resources prudently, said Dr. Schneider. First and foremost, physicians must be prepared to demand the sharing of hospital and physician-specific data.

"They'll want to look at your office records for proper record keeping and documentation," continued Dr. Schneider, adding that physicians can expect periodic quality review, utilization review, and reviews of patient complaints and satisfaction. "Physicians need to know what the procedures are for credentialing, re-credentialing and due process."

BEFORE SIGNING any contract, physicians need to know how its terms will affect their practice and their patients, said Kane. Physicians should consult an attorney with experience representing physicians – not hospitals or corporations – to review the contract and answer any questions, he noted. "You may not like all of the contract provisions, but know what you are getting into; go into it with your eyes open."

If the contract language says one thing, but the contractor tells you something different, have the contract language changed, advised Kane. "No matter what they tell you, when push comes to shove, the contract [is] the final [word]." Physicians should insist on having enough time to review the contract thoroughly and beware of provisions allowing the contractor to change rules, policies or procedures without the physicians' consent. Physicians should know their responsibilities if a provision is changed without notice, he added.

"Some provisions may require you to participate in utilization review, peer review or similar activities that may not be covered by your malpractice insurer," said Kane. "[If so,] specify that you cannot participate in these activities unless the contractor will provide liability coverage for those practices, and make sure it is stated in the contract."

Most importantly, physicians need to know when and how the contract terminates. "Very few marriages are made in heaven, and you need to know how you can get out of them," said Kane. ISMS is ready to provide referrals to legal counsel who are familiar with all aspects of managed care contracts.

Once you've committed to a managed care plan, review it on an ongoing basis, said Dr. Schneider. "What is the denial process? How does the plan really function? Are there too many hoops to jump through?"

Many physicians are apprehensive that managed care plans focus too intently on cost control at the expense of quality. But learning how the plans work and knowing the contract can help alleviate these concerns.

"There are plans organized to facilitate, not impede, care," Dr. Schneider continued. "When managed care works, it gets the third-party payer out of the physician's office and back to the business of costs. As physicians, we are allowed to re-establish our authority over the care of our patients." ■

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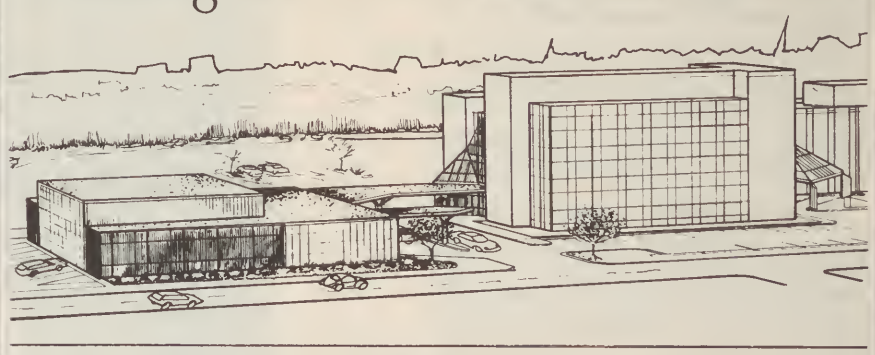
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OBRA '93

(Continued from page 1)

did not include several House of Representatives amendments requesting reduced prescribing and use of medically unnecessary equipment, prohibiting suppliers from engaging in potentially abusive activities and limiting beneficiary liability if suppliers have failed to follow all requirements.

NEW REGULATIONS ABOUT physician ownership and laboratory referrals will be stricter than current Illinois law, ISMS analysts believe. However, further analysis is necessary before the full impact of the regulations can be determined. The current Medicare restrictions on self-referral will be expanded to all government payers, including Medicaid and state programs. Illinois' self-insured state employee health plan may be included.

Restrictions on self-referrals will be expanded from clinical laboratory services to also include physical and occupational therapy services; radiology and other diagnostic services; radiation therapy services; durable medical equipment; parenteral and enteral nutrients; supplies and equipment; prosthetics, orthotics and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. Several exceptions and exemptions apply. For example, in-office ancillary services are exempt from restrictions when provided by the physician or under a physician's direct supervision. In some cases, rural providers are exempt from self-referral limitations to ensure access to necessary services. The new provisions go into effect Dec. 31, 1994.

Under the new budget, Medicare will lose a total of $55.8 billion over five years.

A variety of other changes will be made to Medicare under OBRA '93. Indirect medical education payments will now include interns and residents who work in hospital-controlled community health centers.

After Oct. 1, 1993, Medicare claims processed electronically will not be paid in less than 13 days of receipt, and paper claims will not be paid in less than 26 days. Interest payments will be made on clean claims not paid within 30 days. Currently, interest must be paid on clean claims not paid within 24 days for non-participating physicians and within 17 days for participating physicians.

CHANGES IN MEDICAID are less likely to directly affect physicians, ISMS analysts predicted. States will no longer be required to include drugs on their formularies simply because manufacturers have signed rebate agreements. States will also be allowed more flexibility on formularies to limit Medicaid coverage of prescription drugs.

The new budget law also states that transplants will not be included in the medical services provided to aliens and that effective July 1, 1993, certain comprehensive health clinics will be considered Federally Qualified Health Centers. ■



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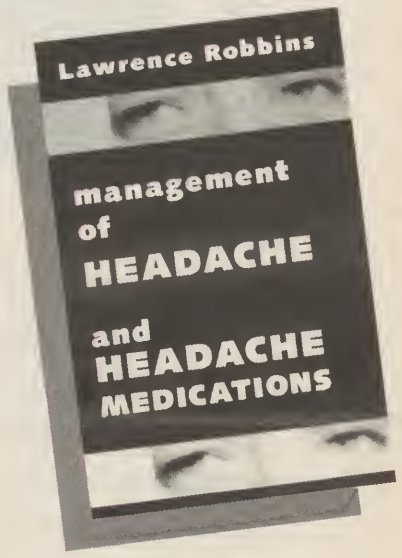
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Health care reform and the solo practitioner

PAGE 19



The growing threat of violence against doctors

PAGE 14

Applications inundate medical schools

RECORD INCREASE: Despite imminent health care reform, more students are choosing to pursue medical practice. By Anna Brown

[CHICAGO] Medical schools throughout the country have received record numbers of applications over the past two years, and Illinois schools are no exceptions, according to admissions officials. Most of Illinois' medical schools are already receiving applications for 1994 at a record-setting pace.

Nationwide, 1993 applications are up 15 percent, according to the Association of American Medical Colleges. This sharp increase could indicate a reversal of the recent downturn in the number of applicants to medical school, observers say.

"We are all experiencing this phenomenon," said Jan L. Schmidt, director of admissions for Rush Medical College in Chicago. Medical schools nationwide have received 43,000 applications for 16,500 slots, she said. Rush saw an 18-percent increase in applications in 1993; a record 4,728 applications arrived for 120 slots.

Other Illinois medical programs also have been deluged with applications. Last year, the University of Health Sciences/The Chicago Medical School was one of three medical programs in the country to receive 10,000 applications, Schmidt said, noting several possible reasons for the high application rate. "In times of

(Continued on page 21)

Prescription drug misuse prompts concern

SENIORS: New statistics indicate concerns about drug misuse are valid. By Anna Brown

[SPRINGFIELD] Recent evidence about the misuse of prescription drugs is confirming what some physicians and health agencies across the country already know: Many people do not take prescription drugs as directed. The problem is especially severe among the elderly, according to the Illinois Department of Alcohol and Substance Abuse and the Illinois Department on Aging.

In this year's National Household Survey, compiled by the

(Continued on page 22)

INSIDE

Talk about prescriptions in October

PAGE 2

UR physicians focus on quality

PAGE 3

Medwatch program seeks physician involvement

PAGE 4

DEPARTMENTS

News Briefs.....2

Commentary.....6

ISMIE Update 9

Classifieds 17

Snapshot.....20



Quincy Herald-Whig/Michael Kipley

A MEMBER OF A CLEANUP CREW in Quincy unloads barrels damaged by this summer's flooding. Gov. Jim Edgar is urging citizens to bring their flood debris – including metal appliances, tires and household hazardous waste – to one of the Illinois EPA's waste collection centers. See story page 5.

IDPH budget increases to fund AIDS programs, HMHK

FISCAL '94: The state budget includes additional funding for several public health programs. By Anna Brown



[SPRINGFIELD] The General Assembly increased the Illinois Department of Public Health's general revenue funding by 15 percent in the fiscal 1994 state budget signed by Gov. Jim Edgar last month. The department's largest line item increases are slated for AIDS programs and IDPH's case management administration of the Healthy Moms/Healthy Kids health care program, aimed at reducing infant mortality in Illinois. The department also expects to receive an additional $29.6 million this year in federal funds for public health programs.

"We were fortunate to receive new funds for key programs, especially after the last couple of years, when we've seen cuts," said IDPH Director John R. Lumpkin, MD. "We were able to double our AIDS activity funding. This was generated by a deep commitment by the governor to adequately address this issue."

"We had a decent budget going in," said Gary Robinson, deputy director for the IDPH office of finance and administration. "The governor's budget was significantly larger than

(Continued on page 23)



Ron Ackerman

RAY NEUPERT receives a free health screening from Donette Owens, RN, at the 1993 Illinois State Fair. St. John's Hospital of Springfield provided the screenings to senior citizens at the State Fair Senior Center Aug. 13-22. More than 30 other exhibitors provided information on senior meal and transportation programs, health insurance, tax relief and discounts.

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Economic credentialing study under way

[SPRINGFIELD] The Illinois Health Facilities Planning Board has begun its study of how economic credentialing decisions affect quality of care, access and the availability of physician services. During the recently completed legislative session, state lawmakers adopted a resolution calling for the planning board to study economic credentialing in hospitals, HMOs, ambulatory surgical treatment centers, medical corporations, clinics and physician group practices. The planning board must report its findings to the legislature and the governor by Jan. 1, 1994.

Physicians who wish to participate in the study or provide information should send relevant material to Ray Passeri, Division of Facilities Development, Illinois Health Facilities Planning Board, 525 W. Jefferson, Second Floor, Springfield, IL 62761. For more information, call (217) 782-3516. ■

Talk about prescriptions in October

COMPLIANCE: A patient-education group works to improve communication between health care providers and patients. By Gina Kimmey

[WASHINGTON] The National Council on Patient Information and Education is preparing for the 8th annual Talk About Prescriptions Month celebration in October. The monthlong program aims to boost communication about prescription medications between patients and their health care providers.

"The goal of Talk About Prescriptions Month is to get health care providers and their patients talking about the medications they are using," said NCPIE spokesperson Erin McClintoch. "We are essentially promoting patient compliance and an awareness of what can happen when patients don't follow doctor's orders."

The planning kits are available to health care providers for $8 each. The



kits contain articles, counseling tips and techniques for improving communication with patients. To help inform patients about using prescription drugs properly, the kits also include medication misuse fact sheets and a resource list.

In addition to offering the planning kits, the council helps physicians organize "brown bag" medicine reviews for senior patients who use multiple medications. At the reviews, doctors can identify possible duplication or negative drug interactions. NCPIE offers starter kits to enable physicians to conduct sessions for as many as 50 patients.

NCPIE represents physician, pharmacy, nursing and other health professional organizations, as well as voluntary health associations, pharmaceutical manufacturers, consumer groups and the U.S. Food and Drug Administration. For more information about Talk About Prescriptions Month or the brown bag medicine review program, contact NCPIE at 666 11th St., NW, #810-M, Washington, DC 20001. ■

Restaurant workers face increased lung cancer risk

[CHICAGO] Food service workers may experience a 50-percent increase in lung cancer risk that can be attributed in part to workplace tobacco smoke exposure, according to a study published in the July 27 issue of the *Journal of the American Medical Association.*

"Environmental tobacco smoke is a significant occupational health hazard for food service workers," said researcher Michael Siegel, MD, of the University of California, Berkeley. Dr. Siegel reviewed studies on indoor air quality in restaurants, bars, offices and homes with at least one smoker, as well as epidemiological studies reporting risk estimates for lung cancer incidence and mortality among food service workers. He concluded that waiters, waitresses, busboys and bartenders face significantly higher risks for lung cancer because of patrons' cigarette smoke.

Dr. Siegel compared the concentrations of carbon monoxide, nicotine and respirable suspended particulates with the lung cancer risk of food service workers and the general population. He said that levels of secondhand tobacco smoke in restaurants were approximately 1.6 to 2 times higher than in offices and 1.5 times higher than in residences where at least one person smoked. Levels in bars were 3.9 to 6.1 times higher than in offices and 4.4 to 4.5 times higher than in residences.

"To protect these workers from the hazards of environmental tobacco smoke, smoking should be prohibited in bars and restaurants," Dr. Siegel said. ■

October targets mental illness awareness

[WASHINGTON] Mental health advocates, physicians, hospital staffs and educators will celebrate Mental Illness Awareness Week, Oct. 3-9. To help plan special events for the week, the American Psychiatric Association is offering a promotion package. The kit includes "Let's Talk About Mental Illnesses" posters, a campaign guide – complete with camera-ready art, ad slicks and sample press releases – project ideas and contacts. The promotion packages cost $90 and are available from the APA/Division of Public Affairs, Dept. MPP, 1400 K St., NW, Washington, DC 20005.

To complement Mental Illness Awareness Week, the AMA and the National Mental Health Association are co-sponsoring a public awareness campaign about clinical depression. The groups have designated Oct. 7 as National Depression Screening Day. According to NMHA, clinical depression strikes more than 12 million adults annually and costs $27 billion in worker absenteeism, lost productivity and health care services. Effective treatment is available, the association said, but only one-third of those who experience clinical depression seek treatment. To obtain clinical depression screening guidelines, physicians may contact the Agency for Health Care Policy and Research at (800) 358-9295. ■

AIDS walk benefits area agencies

[CHICAGO] Since 1990, AIDS Walk Chicago has raised more than $1.2 million for AIDS prevention and care programs. With support from more than 70 businesses and corporations, the fourth annual Walk for Life, will be held Sept. 12. This year's fund-raising goal is $1.2 million, and the proceeds are slated to benefit 13 Chicago agencies dedicated to serving those affected by AIDS and HIV.

"It's a wonderful time, with an enormous group of people from all walks of life," said John Wootton, MD, medical director of Northwestern Memorial Hospital's substance abuse program and an AIDS walk participant since 1990. "As a physician, I work with a lot of AIDS patients. I can help them medically, but there are so many needs I can't address here. All of the organizations receiving money from the walk are support agencies that can provide services the hospital can't."

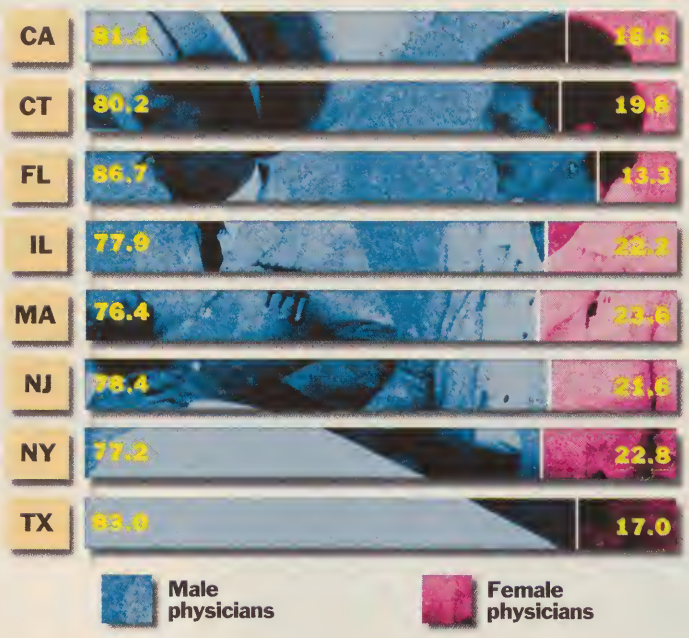
AIDS Walk Chicago gives money to agencies that provide food, information and health care to individuals with AIDS and HIV. These organizations also provide legal, financial and social services to 473 homeless and indigent people affected by the disease, and help 150 AIDS patients maintain their independence by offering them home health care services. Organizations funded in part by AIDS Walk Chicago include the AIDS Pastoral Care Network, Chicago House and Social Service Agency, the Howard Brown Health Center, Stop AIDS Chicago, and the Michael Reese Education and Research Foundation.

"AIDS Walk Chicago has no huge staff to support, so all the money goes directly to these agencies," said Dr. Wootton. "It is an honest endeavor and truly charitable." For more information, call AIDS Walk Chicago at (312) 935-WALK. ■

PHYSICIAN FACTS

Male/Female physician population

The following is a comparison of the percentages of male and female physicians in eight states:



Source: AMA Council on Long-Range Planning and Development

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UR physicians focus on quality

CME: Nearly 300 physicians discuss quality issues during a recent educational seminar.
By Anna Brown

[CHICAGO] Hoping to learn how to better define and measure quality, diplomates of the American Board of Quality Assurance and Utilization Review Physicians attended an Aug. 18 seminar in Chicago. The gathering was the largest CME program in the organization's history. Speakers from various groups – including the AMA, the American Hospital Association and the Joint Commission on Accreditation of Healthcare Organizations – discussed the value of defining quality, stressing methods of measurement and attainment of quality.

"The purpose of this seminar is to procure the opinions of heavy hitters in health care, not only on the subjects of cost, access and reform, but also on quality," said Joseph L. Murphy, MD, president of the quality assurance board and chairman of its board of directors. "We wanted the people most interested and active in medicine to put their stamp on the seminar, and that stamp is quality."

Part of the problem is that there are no standard patients, diseases or doctors. There is no doctor today who has not done everything medically correct and had a bad result.

Highlights of the three-day meeting included a keynote address by James S. Todd, MD, executive vice president of the AMA; and presentations by Paul M. Schyve, MD, JCAHO senior vice president; and John F. Schneider, MD, professor of clinical medicine at the University of Chicago and chairman of ISMS' Third Party Payment Processes Committee.

Dr. Todd discussed several basic concepts about quality but focused mainly on the role of quality under health care reform proposals. Any meaningful reform would have to be based on four principles – universal access, freedom of choice, cost containment and quality of care, he said.

"It's going to be essential for every physician to be involved to ensure that any proposal won't impair the quality of health care," Dr. Todd said, noting that the AMA is prepared to mail an analysis of President Clinton's health care reform proposal to every physician in the nation within a week of the plan's release. "Then we will depend on physicians to educate patients, the community and politicians. We want to make sure physicians have the information to educate legislators."

Calling quality the "first rule of patient care," Dr. Todd said there will be "no room for quality compromise" under health care reform. However, he stressed the difficulty of defining quality.

"Part of the problem is that there are no standard patients, diseases or doctors. There is no doctor today who has not done everything medically correct and had a bad result."

Despite the fact that physicians can treat two patients with the same diagnoses and experience different outcomes, doctors are faced with a public that demands some measure of quality, Dr. Schneider said. Even the most specific and scientific rankings of hospitals and physicians can be misunderstood, he said.

OFFERING AN INSTITUTIONAL perspective on quality in health care, Dr. Schyve noted the importance of studying outcomes to determine quality of care. "Results are

(Continued on page 13)



Michael Candee

Drs. Murphy (left) and Schneider

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REPORT FOR *Illinois Physicians*

E/M CODES AND PLACES OF SERVICE

The following chart shows the possible places of service for the different categories of Evaluation and Management (E/M) procedure codes. Please use this chart to avoid Medicare denials caused by the incorrect E/M code for the place of services.

11	Office	34	Hospice
12	Home	51	Inpatient Psychiatric Facility
21	Inpatient Hospital	52	Psychiatric Facility Partial Hospitalization
22	Outpatient Hospital	54	Intermediate Care Facility/Mentally Retarded
23	Emergency Department	56	Psychiatric Residential Treatment Center
31	Skilled Nursing Facility	61	Comprehensive Inpatient Rehab Facility
32	Nursing Facility	62	Comprehensive Outpatient Rehab Facility
33	Custodial Care Facility		

99201 - 99215	Office/Other Outpatient Services	11, 22, 23, 34, 62
99221 - 99233	Hospital Inpatient Services (Codes Used For Medical Conditions Only)	21, 51, 52, 61
99241 - 99245	Office/Other Outpatient Consultations	11, 12, 22, 23, 33, 34, 54, 62
99251 - 99263	Inpatient Consultations	21, 32, 51, 52
99281 - 99285	Emergency Department Services	23
99301 - 99303	Comprehensive Nursing Facility Assessments	31, 32, 54, 56
99311 - 99313	Subsequent Nursing Facility Care	31, 32, 54
99321 - 99333	Domiciliary, Rest Home, Custodial Care	33
99341 - 99353	Home Services	12

(Issue: 09/10/93 - DB)

Medwatch program seeks physician involvement

REPORTING: A new FDA program simplifies reporting adverse drug reactions and product defects.
By Gina Kimmey

[WASHINGTON] The U.S. Food and Drug Administration announced a new program this summer aimed at encouraging health professionals to report serious problems in FDA-regulated products. The program, Medwatch, is simpler and more efficient than the process previously used for reporting adverse drug reactions and product defects. The new program has the support and participation of the AMA, the American Pharmaceutical Association and more than 50 national specialty societies.

Before Medwatch, the FDA tracked drug and medical device performance through mandatory reports from manufacturers, device distributors, and hospitals and labs using the products, as well as through voluntary reporting by health care professionals. But an FDA survey indicated that as many as 50 percent of physicians were unaware of the agency's previous adverse events reporting system.

Medwatch's new simplified reporting form replaces five other forms previously issued by the FDA for the same purpose. The self-addressed, one-page form can be folded and mailed postage-free. The information will be printed in several publications, including the *Physicians' Desk Reference*, the *FDA Medical Bulletin* and *AMA Drug Evaluations*. In addition, the FDA has established a 24-hour toll-free telephone number for physicians to report and receive adverse event information.

"Medwatch is not just a new FDA system; it is a way of making reporting of adverse events and product problems a part of the culture of health care providers," said FDA Commissioner David A. Kessler, MD.

> *Physicians, nurses and others who care for patients are the first to know when a drug does not perform as it should.*

Physicians who treat geriatric patients, in particular, should participate in this program, said Vincent A. Costanzo Jr., MD, a member of ISMS' Committee on Drugs and Therapeutics. "Doctors need to get involved in this program. The information gathered will benefit the doctor writing the prescription, as well as the patient receiving it."

Dr. Costanzo cited a 1991 study conducted by the U.S. Department of Health and Human Services stating that more than half the deaths attributed to drug reactions involve people who are 60 or older. The study also indicated that the risk of an adverse drug reaction increases 33 percent for individuals between the ages of 50 and 59, and more than doubles for the Medicare population.

Clinical trials preceding product approval typically include data on several hundred or several thousand patients. After drugs or medical devices are on the market, wider use generates more data about the safety and efficacy of the products, said Dr. Kessler. Medwatch is designed to enable the FDA to learn this information as soon as it is gathered by health professionals.

Health care providers should report adverse events even if they only suspect that a drug or product might be the cause, Dr. Kessler said. Physicians should report incidents involving a patient's death, life-threatening illness or injury, hospitalization, disability, congenital anomaly or "any experiences that require intervention to prevent permanent impairment of health," the FDA said. Medwatch will also collect information about suspected contamination, questionable stability, defective components and poor packaging or labeling of regulated products.

"Physicians, nurses and others who care for patients are the first to know when a drug or medical device does not perform as it should," Dr. Kessler said. "The sooner they report it to the FDA, the faster the agency can analyze the problem and take corrective action."

The FDA will hold a special conference on medication- and device-induced problems next year. It will also ask medical, pharmacy, dental and nursing schools to include adverse event and product problem recognition and reporting in their curricula.

"Physicians need to constantly look for ways and means of giving patients the best medical care possible – that's why they wanted to be doctors in the first place," said Dr. Costanzo. "One way to work toward that goal is having the knowledge this program can provide."

For more information about Medwatch or to receive voluntary reporting forms, physicians may call the FDA at (800) FDA-1088. Concerns about vaccines will continue to be reported separately through the FDA's Vaccine Adverse Events Reporting System at (800) 822-7967. ■

Ambulance company pays $3 million for fraud

[MINNEAPOLIS] In the largest health care fraud settlement in Minnesota, the U.S. government received $2.5 million and the state of Minnesota received $450,000 from an ambulance company accused of fraudulently overcharging Medicare and Medicaid for excessive, unnecessary ambulance rides, according to the state's attorney general's office.

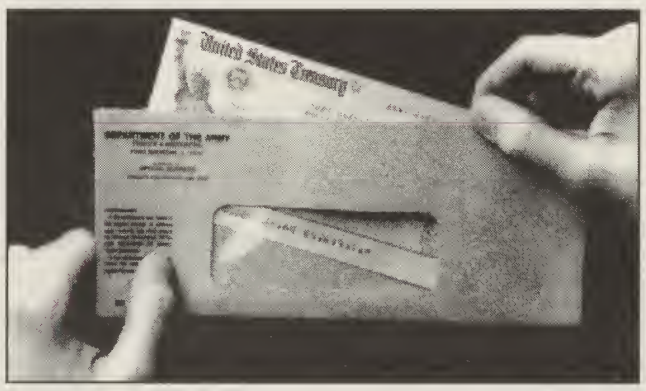
HealthSpan Transportation Services "falsely billed Medicaid and Medicare for basic life-support ambulance transportation, claiming the rides were medically necessary, when a lesser form of transportation would have been appropriate," said U.S. Attorney Frank Hermann.

Under the settlement terms, the company will also provide $97,542 in free transportation for uninsured, low-income residents to compensate for overpayments by Medicare patients who made copayments for ambulance service when a van ride would have sufficed. The average difference between a consumer's copayment for an ambulance ride and a van ride is about $52.

Charges were filed after an audit and subsequent investigation of claims submitted by HealthSpan between January 1988 and Aug. 31, 1991, revealed a significant number were miscoded or falsified. In addition to the monetary payments, the company must also develop and implement an audit work plan to ensure the accuracy and validity of its Medicare and Medicaid claims, and train employees who prepare and submit claims. ■

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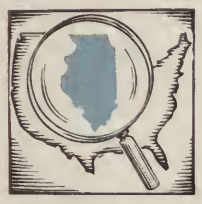
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Flood cleanup focuses on health hazards

RECOVERY: Illinois' public health efforts have been exemplary so far, but officials caution the danger is far from over.
By Gina Kimmey



[SPRINGFIELD] Illinois citizens and public health officials can take pride in their efforts to fight the great flood of 1992 and prevent widespread public health tragedies, said James L. McGee, MD, chairman of the State Board of Health.

"Illinois' response was clearly one of the best of the nine states involved in the flood, thanks to the Illinois Department of Public Health and the tireless efforts of local health departments, [which] took on much of the burden," said Dr. McGee. The board worked closely with IDPH to ensure that residents in flooded areas took precautions to safeguard their health, he said.

"I think everything was in place in Illinois. There was no scrambling around when the crisis began. We had a plan in place, and everyone just did what he or she had to do," Dr. McGee explained. Now that the floodwaters have begun to recede, officials are concerned that residents may believe the crisis is over and fail to realize that public health hazards still exist. As the recovery process begins and people clean up their flooded homes and businesses, IDPH urges residents to protect themselves from injury and illness, according to IDPH Director John R. Lumpkin, MD.

"Mosquitoes, contaminated food, and failure of public and private water supplies and sewage systems are some of the problems flood victims may encounter," said Dr. Lumpkin. He advised citizens returning to flooded areas to make sure they have received a tetanus shot in the last 10 years and to shield any areas of broken skin, where tetanus bacteria typically enter the body. If individuals have open sores that are exposed to contaminated water, they should disinfect the wound immediately and consult a health care professional.

Public health officials are also concerned about the threat of mosquito-borne encephalitis, said Dr. McGee. "IDPH, in conjunction with the Centers for Disease Control and Prevention, is currently monitoring the mosquito population and will test for encephalitis."

The department advises citizens to help eliminate breeding areas on or near their property by discarding old tires, buckets, tin cans and other containers that harbor small amounts of water. Property owners should also clear drainage ditches of debris, brush and other excess vegetation. To help prevent the spread of waterborne diseases, people should wash their hands with soap and clean, warm, running water before touching food or babies or handling anything that may enter a person's mouth, IDPH said.

Private well-owners should contact their local health department for help in having their wells tested. IDPH also tests well water, and if it is contaminated, department staff explain how to disinfect it. When in doubt about the safety of any food or beverage, discard it, said Dr. Lumpkin, adding that residents should not eat food that had any contact with floodwater. These and other tips are included in the IDPH's "After the Flood" brochure, available from local health departments or the IDPH Division of Communications, 535 W. Jefferson St., Springfield, IL 62761.

AREAS MOST SERIOUSLY affected by the flood include Quincy and surrounding Adams County. The Adams County Medical Society flood fund, "Health Aid '93," supports immunization programs for flood victims and levee workers, and a mosquito abatement program to com-

(Continued on page 21)



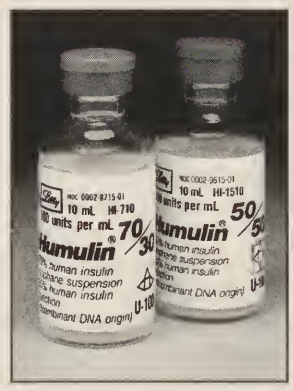
Dr. McGee



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EDITORIAL

What you get from ISMS membership

In any association, members occasionally ask, What am I getting out of my membership? One of the primary benefits of membership in ISMS is the opportunity to become a policyholder in ISMIE, the physician-first insurer and the oldest physician-owned professional liability insurer in Illinois. According to a recent survey, most policyholders surveyed were well-satisfied with ISMIE services and were well-aware of ISMIE services such as risk management seminars and litigation preparation. But they did not know that ISMIE offered a clinic/group discount program, trial reimbursement or suspended coverage.

Another benefit of ISMS membership is legislative advocacy on such critical issues as economic credentialing and caps on noneconomic damages. At the end of the recent legislative session, the Senate adopted an ISMS-backed resolution calling for the Illinois Health Facilities Planning Board to study the effects of economic credentialing decisions on quality of care, access and the availability of physician services. The study is currently under way.

ISMS also helped state legislators understand the issue of caps on noneconomic damages in civil cases, including medical malpractice. Of the two bills that would have capped pain and suffering awards at $250,000, one passed in the Senate. Although both ultimately failed to advance, they helped lay the groundwork for passage of future legislation.

Related to legislative advocacy is 1994 election activity. ISMS hopes to help elect candidates who are willing to listen to physicians on health care issues that are important to you and your patients. IMPAC, which receives contributions from physicians and their spouses, provides valuable campaign funds to candidates in close races.

With the announcement of the Clinton health care reform plan imminent, ISMS is ready to communicate members' positions on state and national health care reform issues. Any plan will be judged according to inclusion of meaningful tort reform and the continuation of high-quality health care in the face of proposals that patients be treated by unqualified health care providers.

With your membership, you also have the chance to serve on the Society's councils and committees. It is at this level that most of the hands-on work is done. Policies and positions are developed, and brochures and other publications are formulated to help keep members informed.

You can make the most of your ISMS membership by renewing for 1994 and becoming actively involved in your Society.

PRESIDENT'S LETTER

Assessing health care reform

By Arthur R. Traugott, MD



It is not necessary to scrap or completely restructure the current system.

We hope that President Clinton will announce his administration's health care reform plan later this month. Given the lack of details released so far, there are still many unanswered questions. When evaluating any proposed federal or state plan, ISMS members should be ready to ask questions. Some of the questions in my mind are

• Does the proposed health care reform plan use the current system as its basis, or does it replace the current system?

The current health care delivery and financing systems have many advantages. However, there are problems that require some restructuring and innovation. It is not necessary to scrap or completely restructure the current system.

• Does it use as its basis the current public-private system of health care financing?

Single-payer systems would require radical restructuring of the health care financing system. Such systems would likely be government run – either directly or through regulations. They would probably cause funding problems and might reduce access.

• Does it provide equal access to a guaranteed health plan, including preventive care, for all citizens?

Everyone should have access to a guaranteed health benefit plan that includes cost-effective preventive care. The components of that exact benefit package would be based on needs as well as budget constraints. Employers and individuals should be able to purchase coverage beyond the guaranteed health benefit plan if they so desire.

• Does it fairly distribute the costs of improved access?

We all benefit from having a healthy population. Our access problem is a societal problem. The costs associated with attempts to resolve it should be borne fairly by all segments of society.

• Does it provide for basic health insurance reform?

Insurance companies should not be allowed to discriminate based on pre-existing health conditions. Risk rating should be reduced or eliminated. Insurance companies should be required to use community rating, which should be based on geographic factors, age, gender and behavior.

The Employee Retirement and Income Security Act of 1974 should be changed in two ways. First, ERISA-exempt plans should be required to offer at least the guaranteed health benefit plan. Second, ERISA-exempt plans should not be exempt from all state laws, especially tax laws.

• Does it include professional liability reform to reduce costs?

Professional liability reform would decrease defensive medicine and would moderate liability premiums. Caps on noneconomic damages should be legislated.

• Does it reduce administrative and paperwork costs?

To reduce these costs, the main approach is standardizing administrative requirements among payers.

• Does it include preventive services and health care education?

Health care education is crucial in helping consumers make good choices and preventing medical problems and their costs. Extensive public health education programs should be considered, beginning in elementary school.

• Does it improve the practice of medicine and put controls back in the hands of the professionals?

Present-day efforts to control costs have resulted in the micromanagement of medical practice. Antitrust laws have made it difficult to impossible for the profession to discipline itself. Any reform must permit physicians to conduct better peer review, monitor their practices and negotiate with entities attempting to manage care.

My list of questions is not comprehensive. No doubt, you, too, have questions about the proposed reform plans. If so, please communicate your concerns to me so that I can add them to the list.



"Unmitigated gall! What kind of diagnosis is that?"

GUEST EDITORIAL

Handgun violence: A public health issue

By Willard A. Fry, MD

The recent murder of Martin R. Sullivan, MD, in his office in Wilmette was a shock to all of us, particularly practicing physicians who view such an egregious violation of the physician-patient relationship as unacceptable. The handgun murder of James Jordan, the father of Illinois' most famous living citizen, only helped to highlight the problem of handgun violence in America.

We have allowed ourselves to become desensitized to the facts that handgun violence is a daily affair in America and that it exists to a degree totally disproportional to its prevalence in other developed countries in the world. The tolerance, and even acceptance and encouragement, of the American public for excessive violence in the movies and on television only serves to increase the desensitization process.

We have been part of the desensitization process ourselves. In our medical training programs, references to the "local knife and gun club" are supposed to elicit laughter from the medical students and residents. The reality is that the "club members" are usually underprivileged, poorly educated and often dangerous members of our society for whom handgun ownership is totally inappropriate. The unrestricted manufacture, distribution and sale of concealable handguns and assault weapons must cease.

The mere presence of such lethal weapons in our homes is a health hazard, as is evidenced by the countless sad injuries and even deaths that occur when small children come across such weapons in their homes or when domestic altercations – that are initially nonviolent – turn into manslaughter or murder cases simply because there was a handgun in the home. All of this has little to do with hunters who own shotguns and rifles or with the Second Amendment to our Constitution, which gives us the right to form a militia and the subsequent right to bear arms.

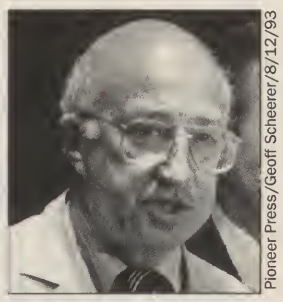
Our neighbors to the north, the Canadians, enjoy hunting, and many Americans go to Canada to hunt. However, Canadian handgun regulations have rendered the amount of handgun violence in Canada dramatically less than what we experience in the United States. It is time for those of us in the healing profession to exert a positive influence on this public health issue and rectify a situation that is rapidly growing out of control.

There are positive actions all of us can take. For example, support the Illinois Council Against Handgun Violence (202 S. State St., Suite 926, Chicago, IL 60604; (312) 341-0930). Contact your elected public officials, both state and federal, and urge them to enact more effective gun control. Specific measures would include longer waiting periods and background checks (such as the provisions detailed in the Brady bill), stricter regulation of gun dealers, accountability and responsibility of gun dealers for the products they sell, registration of all handguns with local law enforcement authorities and an outright ban on high-velocity assault weapons for the general public.

I was part of the surgical team that treated the Winnetka schoolchildren shot with Laurie Dann's handgun. What a senseless horror.

I knew Dr. Sullivan for 27 years and worked with him in the surgical teaching programs at Northwestern University Medical School. He was a kind and talented surgeon. The handgun murder of Dr. Sullivan in his office outraged us.

Handgun violence is out of control in America. Effective gun control can save lives. It is a public health issue that deserves the support of the medical profession, because it is the right thing to do.



Pioneer Press/Geoff Scheerer/8/12/93

Dr. Fry *is a member of the board of directors of the Illinois Council Against Handgun Violence. He is a senior attending physician at Evanston Hospital.*

GUEST EDITORIAL

Lawyers against medical malpractice reform

The American Bar Association, ever eager to uphold the liberal piety of the moment, has happily jumped on the health reform bandwagon. The ABA even has its very own working group on health care. And the consensus at the recent ABA annual meeting was that Bill Clinton's plan to create "a fair system where everyone in the United States is guaranteed basic universal health care" is an idea whose time has come.

Gung ho as they are for a radical overhaul of the nation's health care system, however, the ABA lawyers are convinced that one aspect of that system should remain untouched. Indeed, the main thrust of the report issued at the meeting by the working group was that imposing limits on the money awarded to victims of medical malpractice is a very bad idea.

According to the chairman of the task force, for one thing, medical malpractice insurance premiums amount to only 1 percent of overall medical costs; limiting payments to victims, and presumably lowering doctors' premiums, would thus only constitute a drop in the cost-containment bucket. Then there's the fact that most malpractice suits end in very small settlements. And then, of course, there is the issue of fairness to the victims. Said one personal-injury lawyer, "I've never found any victim who has been seriously injured and believes that their damages should be limited to some arbitrary figure of $250,000."

Now, anyone who has had dealings with doctors in recent years knows that malpractice suits have been a significant factor in rising medical costs. There is, of course, the expense of malpractice insurance premiums, which for certain specialties is painfully high – even forcing some doctors to abandon their practice. That expense is inevitably passed on to patients; but there are other, less direct, costs as well. The family doctor no longer says, "Take two aspirin and call me in the morning." He says, "Better come on in and let us take a look at you," and "Just to be on the safe side, let's take some blood, do a smear, run an EKG, get a CAT scan."

Admittedly, the miracles of modern technology save lives, and we are glad to have access to them when something serious is wrong. But occasionally we do end up spending hundreds of dollars on tests when a $2 bottle of aspirin – and a little time – would serve us just as well. In those cases, there can be no question that the doctor had visions of a courtroom – and of million-dollar damage awards – dancing in his head.

Call it cynicism, but the thought does spring to mind that the prospective loss of hundreds of thousands, possibly even millions, of dollars in income plays some role in the ABA's opposition to limiting medical malpractice awards.

And by our side in that courtroom would, of course, be our trusty lawyer. He would be there waiting to collect his fair share of whatever damages were awarded. Usually, that comes to one-third of the total. If the total is, say, a million dollars, the lawyer stands to gain about $330,000; if it is $10 million, he comes out ahead by a cool three million.

But if an "arbitrary" limit of $250,000 were imposed, his take would be less than $90,000. Call it cynicism, but the thought does spring to mind that the prospective loss of hundreds of thousands, possibly even millions, of dollars in income plays some role in the ABA's opposition to limiting medical malpractice awards.

This editorial originally appeared in the Aug. 11 edition of the Washington Times. *It is reprinted with permission.*

Quarterly premium payments due

Don't jeopardize your malpractice insurance coverage. The Exchange is sending all policyholders reminder notices that quarterly premium payments are due Oct. 1. If your payment is not received by then, you will receive a cancellation warning. If your payment is not received by Oct. 15, your policy will be cancelled on that date, and all certificate holders on record, such as your hospital, will be notified. To reinstate your policy after Oct. 15, ISMIE must receive and process your premium installment by Oct. 26. Policyholders who have any questions or concerns may contact the Exchange underwriting division at (312) 782-2749 or (800) 782-ISMS. Please allow seven working days for mailing and processing your premium payment. ■



This man was involved in 42,000 surgeries last year.

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Malpractice Roundup

PAGE 10

ISMIE Update

Exchange Quarterly Premiums Due

PAGE 7

Tort reform battles rage in several states

CAPS: The uphill fight for malpractice reform continues, with some states faring better than others. By Gina Kimmey

[LANSING, MICH.] Although the Clinton administration has provided few details about its approach to malpractice reform, many states are forging ahead with legislation to help control rising medical malpractice costs and runaway jury awards. Like ISMS, state medical societies across the country are looking for ways to enact meaningful tort reform measures. North Dakota, Mississippi and Michigan welcomed new tort reform laws during their spring legislative sessions, while an Arizona measure stalled, and Alabama experienced a severe setback.

Following efforts by a coalition of physicians, hospitals, businesses and industry, Michigan Gov. John Engler signed a bill July 8 requiring plaintiffs to notify defendants about lawsuits and their legal basis 182 days before they are filed. The bill also tightens restrictions governing qualifications for serving as expert witnesses and increases the limit for noneconomic damages to $280,000. The previous limit was $250,000. Under specific circumstances, the cap is raised to $500,000. These exceptions include cases in which plaintiffs suffer certain types of spinal cord and brain injuries, and injuries that permanently impair their cognitive capacity or reproductive capability.

The bill is scheduled to take effect in April 1994. It was introduced after surveys by the Michigan State Medical Society revealed that more than half the physicians receiving residency training in Michigan do not plan to practice there. The most frequently cited reasons for leaving Michigan were the fear of being sued and the costs of medical liability insurance.

North Dakota Gov. Edward Schafer recently signed a measure limiting punitive damages to double the compensatory damages or $250,000, whichever is greater. The law prohibits plaintiffs from introducing evidence about defendants' net worth when the court is determining punitive damages. It also prohibits punitive awards in cases in which there are no compensatory damages.

In Mississippi, the legislature passed a product liability law featuring many of the same punitive damages provisions included in the North Dakota law, such as a requirement that any punitive damages must be "rationally related to the harm caused." Both the North Dakota and Mississippi laws require that "clear and convincing" evidence be presented before a court finds a defendant liable for punitive damages.

An Arizona law, originally scheduled to take effect July 17, was put on hold by a group of trial lawyers and victims' rights advocates who call themselves Fairness and Accountability in Insurance Reform. Because of the group's efforts, the law will be placed on the November 1994 ballot for reconsideration. The referendum calls for repeal of the law's provisions that plaintiffs disclose all sources of insurance and that they repay their insurers if duplicate payments are made by other insurers. Also in jeopardy is a rule allowing insurers' lawyers to obtain the medical records of plaintiffs and their family members from the plaintiffs' doctors without their consent.

A June 25 ruling by the Alabama Supreme Court overturned the state's 1987 cap on punitive damages. The court

(Continued on page 10)

Caps at work in California

California tort reformers prepare to defend a caps law that has provided malpractice stability since 1975. By Gina Kimmey

California's plaintiff bar is threatening an 18-year-old California law limiting noneconomic damage awards in medical malpractice cases. The Medical Injury Compensation Reform Act was enacted in 1975, after California became one of the first states hit by the nationwide medical malpractice insurance crisis in the 1970s. Now, with the end of a five-year truce between California's plaintiff lawyers and tort reformers, the two sides are preparing to do battle over the law again.

[The cap] has been the biggest contribution to MICRA's success in holding down malpractice insurance rates in California.

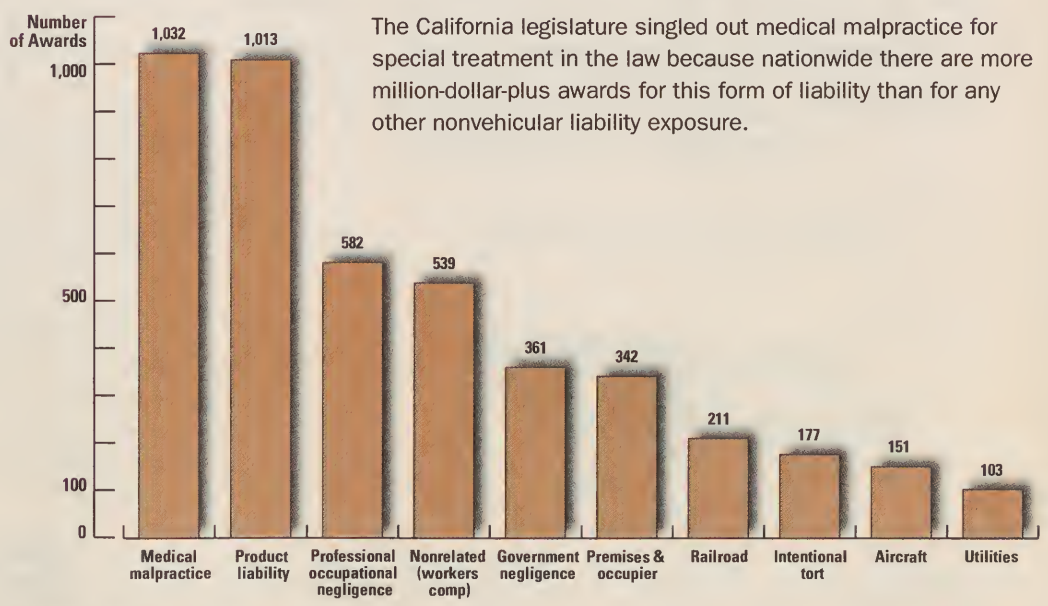
From 1968 to 1974, malpractice claims filed against California physicians rose 200 percent, and the frequency of awards in excess of $300,000 increased 1,100 percent, according to Californians Allied for Patient Protection, a coalition dedicated to preserving MICRA. As a result, malpractice insurance premiums for California physicians jumped 400 percent between 1974 and 1975, making liability coverage either too expensive or unavailable, CAPP said. Unable to pass the cost on to their patients, many physicians and clinics were forced to close their doors. That left many cities with only emergency care for area patients.

"There was a groundswell from patients and health care providers to address the 1975 crisis," said CAPP President Jay Dee Michael. "Hospitals were discontinuing high-risk services; doctors were withholding services rather than practicing without insurance."

On May 1, 1975, physicians in northern California went on strike. The California Medical Association, ad hoc physician committees and individual doctors and patients launched a highly focused lobbying effort pushing for legislation that would alleviate the medical malpractice situation. Two weeks into the strike, then California Gov. Edmund Brown Jr., called a special session of the legislature to deal with the cri-

(Continued on page 11)

Million-dollar verdicts reported by liability Nationwide, 1962 – 1990



The California legislature singled out medical malpractice for special treatment in the law because nationwide there are more million-dollar-plus awards for this form of liability than for any other nonvehicular liability exposure.

Source: MICRA, Jury Verdict Research

Tort reform battles

(Continued from page 9)

ruled the cap violated Alabama's constitution by impairing a jury's traditional function of awarding damages. "The legislature cannot prohibit juries from awarding an amount commensurate to the wrongdoing shown by evidence in a particular case," the court stated. "Once a jury is demanded by either party, the jury has the constitutional authority to determine what amount, if any, of punitive damages is awarded."

"We were disappointed by the ruling but not surprised," said Vic McLean, public relations director for the Medical Association of the State of Alabama. He noted that the decision is consistent with previous court rulings. For example, in October 1991, Alabama's high court struck down a $400,000 cap on noneconomic damages in medical malpractice cases and a clause requiring judgments of $150,000 or more to be structured over time.

"We know a cap for pain and suffering is really needed, but we don't see it on the horizon for Alabama," McLean said. "We have reverted back to pre-1987. At this point, we don't think we will have [tort reform] unless a federal mandate is enacted that pre-empts state law." ■

MALPRACTICE ROUNDUP

New York hikes rates

New York physicians are facing an average 14-percent increase in malpractice insurance premiums this year, following four years without an increase, the *National Underwriter* reported. On July 26, the New York Department of Insurance granted the rate hike because of an increase in the frequency of losses filed and in the severity of claims. In 1988 and 1992, New York's 25,000 individually insured physicians saw no change in their premiums, and in 1990 and 1991, their premiums were reduced by 5 percent. The current increase is retroactive to July 1. ■

Medicaid patients more litigious?

A misperception that Medicaid patients are more likely to file malpractice suits than are non-Medicaid patients may be restricting access to prenatal care for indigent pregnant women, according to an article in *Advances*, the newsletter of the Robert Wood Johnson Foundation. Studies funded by the foundation showed that Medicaid patients were no more likely to sue than are other patients. However, the studies found that the average claims paid to Medicaid patients were at least three times higher than those paid to non-Medicaid patients. The researchers theorized that the low rate of claims filed by Medicaid patients, coupled with the larger average settlements for those Medicaid clients who did sue, meant that indigent patients with less severe injuries may have difficulty obtaining legal services. ■

Florida court upholds caps

A recent Florida Supreme Court decision established that caps on noneconomic damages in medical malpractice actions would not violate the right of access to courts under the state's constitution, as reported in *Medical Malpractice Law and Strategy*. The ruling upholds Florida's cap on pain and suffering and other noneconomic damages in medical malpractice suits. Florida law allows either party in a medical malpractice action to request arbitration. With arbitration, noneconomic damage awards will be limited to $250,000. If the plaintiff refuses arbitration, noneconomic damages will be held to $350,000. However, if the defendant refuses arbitration and insists on a trial, no cap will apply. ■



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AIR FORCE

MICRA

(Continued from page 9)

sis, and the strike ended. With a special session, the governor and lawmakers could concentrate solely on the medical malpractice crisis.

Former Assemblyman Barry Keene, author of MICRA and chairman of the California Assembly's Health Committee, said all interested parties – including physicians, lawyers, insurance companies and patients – knew they would have to make sacrifices to reach a fair and rational solution. The result was MICRA, a law carefully drafted to include all necessary reforms and to prevent interest groups from sabotaging any single provision, Keene said.

AS ENACTED, MICRA sets a sliding scale for lawyers' contingency fees, allows evidence of plaintiffs' compensation from "collateral sources" such as health insurance and permits insurers to make periodic payments when future damages exceed $50,000. The law's most significant provision, however, is a $250,000 cap on noneconomic damages.

"[The cap] has been the biggest contribution to MICRA's success in holding down malpractice insurance rates in California," Michael said. "It allowed more predictability in determining the degree of risk involved in underwriting malpractice insurance and provided greater overall stability in the malpractice insurance marketplace."

According to Keene, several factors contributed to MICRA's success in the state legislature. The bill's authors had preliminary discussions with the governor and reached a consensus on several points, avoiding a potential veto. In addition, they obtained leadership support in both houses, which ensured that competing bills would not advance. Keene also credits the immense public support for the bill. "Perhaps one of the most significant political forces involved in the medical malpractice crisis was the ability of local doctors to arouse their patients and have those patients demand substantial reform," Keene wrote in a 1975 report.

Michael said he remains confident that MICRA will not be repealed. "We have formed a coalition specifically devoted to preventing that from happening." Established in November 1991, CAPP was formed with the cooperation of more than 60 member groups, including the state's medical, hospital, nurse and trade associations; all of California's doctor-owned insurance companies; all the state university medical schools; and several major health plans, such as Kaiser Permanente and Blue Cross of California.

"[MICRA] has kept costs down," Michael said. "It has reduced the amount of frivolous suits and large awards, and has ameliorated the settlement hammer. Money goes to injured patients, not attorneys. Suits are settled faster and at a lower rate. But most important, MICRA assures that all patients who sue and prove their case will get paid.

"The law has stabilized California's insurance industry," he continued. "It has kept medical malpractice insurance rates affordable for everyone, resulting in virtually 100-percent coverage for all health care providers in the state." MICRA also benefits patients, he said. "An injured patient can't collect from a physician with no insurance." ■

ISMS continues fight for Illinois caps

[CHICAGO] Illinois physicians have been working for several years to convince state lawmakers to enact tort reform measures resembling those in California's 1975 Medical Injury Compensation Reform Act. "California has the most comprehensive package of any state, and it now has several years of experience to show that tort reforms really work," said ISMS President Arthur R. Traugott, MD. "However, a major piece that we are missing here in Illinois is a cap on noneconomic damages."

A cap would make Illinois' medical malpractice climate more rational and predictable by allowing insurance companies to more accurately predict rates for physicians and by ensuring remuneration for patients who have been truly injured through malpractice, he said. A cap would also reduce the practice of defensive medicine, said Dr. Traugott.

ISMS' most recent bid to enact a $250,000 cap on noneconomic damages was launched during the 1993 spring legislative session. Although the bill passed the Illinois Senate, it failed to emerge from the House Judiciary I Committee. ISMS will seek passage of caps legislation in future sessions, Dr. Traugott said.

– Gina Kimmey

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Michael Candee

Hollinger

'Front line' employee wins August award

Marcella Hollinger, the August winner of the ISMS Employee of the Month Award, was nominated for her "outstanding professionalism and support," said Jeffrey M. Holden, ISMS chief operating officer, making the presentation at the Aug. 2 award ceremony. Calling her position "front line," Holden said the award "goes to someone within ISMS who quietly and efficiently does a very important job for our members."

Hollinger, the Society's director of education and accreditation, works with Illinois physicians and hospital medical staffs to ensure high-quality continuing medical education. "Marcella's duties involve not only working with physicians to assess the quality of medical education in a wide variety of medical settings, but also making sure that ISMS' status as an accreditor and provider of CME is conducted with the highest possible standards," Holden said.

"Working for ISMS has given me the opportunity to work with really fine, hardworking physicians," Hollinger said, accepting her plaque and $200 check. She added that their commitment and dedication in the face of hard work have given her a benchmark for what Physician-First Service is all about.

Hollinger's physician nominator said, "Her support, creativity and problem-solving skills resulted in a four-year accreditation award for ISMS."

Physicians may nominate a staff member by calling the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■

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*In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

†Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03).

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Claritin®
10 mg TABLETS (loratadine)

Please see back of following page for brief summary of full Prescribing Information.

FOR THE NAS
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UR physicians

(Continued from page 3)

used to make judgments about quality," Dr. Schyve said, explaining that although a physician's performance can be controlled by guidelines such as practice parameters, a doctor also has to weigh the risks and benefits of treatments, a process that is never perfect. "We must learn what is practical for us to actually control.

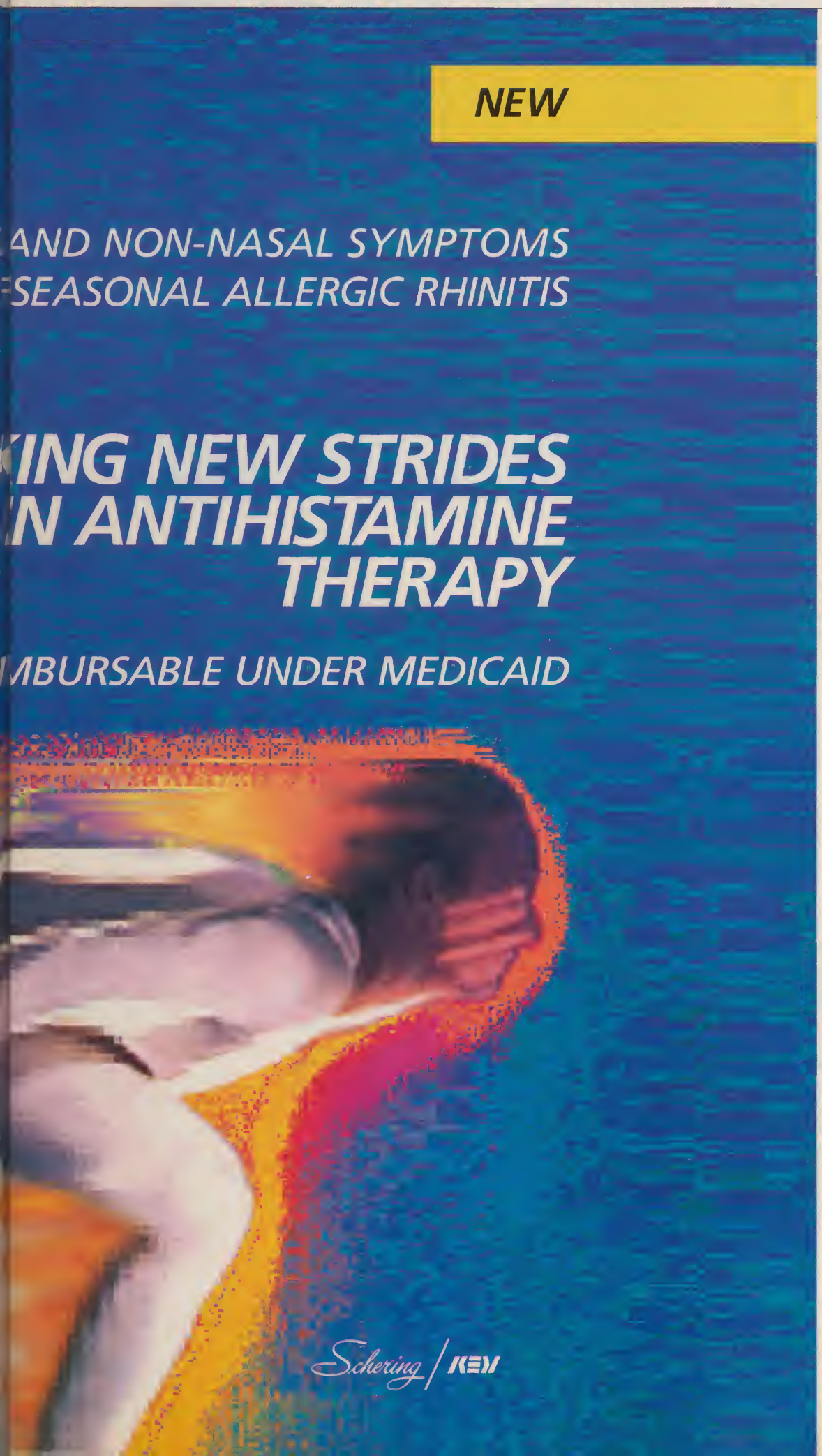
"We have to understand objectives to design processes well," Dr. Schyve continued. "Then we want to know how well the process is functioning. The only way to do that is to measure." He explained that treatment outcomes and processes must be measured and that the effect of some therapies must be measured continually. The ultimate goal is meeting patients' needs and expectations, he said.

Individual performance should also be measured through peer review, Dr. Schyve said, stressing that this review must be performed by "peers who understand by training and experience what that person should be doing."

"Creating an absolute measure for hospitals or physicians is not possible," Dr. Schneider noted. Instead, he advocated implementing practice guidelines to show that institutions are providing high-quality – not just low-cost – care.

"Properly developed guidelines should allow others to come to the same conclusions," Dr. Schneider continued. The provider's skill is also a component in using practice guidelines, and those guidelines must be modified to address particular types of patients and situations, he said. "The use of practice guidelines is sometimes considered 'cookbook' medicine, [but] chefs don't follow their recipes like slaves. It's not the recipe that leads to the quality product. It also depends on your skill and expertise." Physicians should decide how guidelines can best be changed to fit the situation and their skill level, he said.

Dr. Schneider stressed that the implementation of practice guidelines and measurements should be approached as scientific studies, not as marketing tools. "Improvement will take place in small steps," he said, adding that he believes studies and analyses of practice guidelines initiated by physicians should not be viewed as punitive. In fact, he said, they could lead to improved physician-patient discussions about their health care options, which would result in more-informed patient choices. "My hope is that physicians will be able to use practice parameters to facilitate quality improvement in the 1990s and beyond." ■



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(For full Prescribing Information, see package insert.)

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CONTRAINDICATIONS
CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS
General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: Drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, ketoconazole, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS
Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

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PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing.
Body As A Whole Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.
Cardiovascular System Hypotension, hypertension, palpitations, syncope, tachycardia.
Central and Peripheral Nervous System Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.
Gastrointestinal System Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.
Musculoskeletal System Arthralgia, myalgia.
Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido, nervousness.
Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginitis.
Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.
Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.
Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema; abnormal hepatic function including jaundice, hepatitis, and hepatic necrosis; alopecia; seizures; breast enlargement; erythema multiforme.

OVERDOSAGE
Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdosage, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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VIOLENCE

The growing threat of violence against doctors

Physicians should be on guard whether they're practicing medicine in hospitals or private settings.

BY RICK ASA

Friday the 13th has begun for Neil E. Winston, MD, an emergency-medicine physician who has practiced at several Chicago-area hospitals for nearly 10 years. In most urban ERs, where the results of street violence are delivered consistently, every day seems like Friday the 13th.

At the Michael Reese Medical Center, things are heating up by 10:30 a.m. Dr. Winston and a nurse have already been verbally attacked by an angry, aggressive patient who was cut on the hand by her spouse. "This is nothing," said the nurse. "We've taken guns, knives, linoleum cutters, screwdrivers – everything from patients when they come in here. Sometimes it seems like everyone carries something."

Resident Alicia Herman, MD, on a rotation in the ER at Michael Reese, said violence does not stop in the ER. "Even on the floor there can be problems. There have been several patients I've had to call security on. In my experience, at least 75 percent have been drug related. They do a good job of screening for weapons here in emergency, but it's probably not difficult to get something through to hurt someone."

ER nurse Pamela Brown, chairman of an Illinois Nurses Association task force on violence in the workplace, said she has seen a significant increase in weapons confiscated and injuries from violence even at her 250-bed, rural hospital in Quincy.

"You know the old saying," Dr. Winston added, 'where there's a will there's a way.' When I was young, [the feeling] was, 'Let's put up our dukes.' Now, it's basically, 'Let's get a gun and cap someone.' [An attacker] may not even be a person you have a conflict with."

Dr. Winston knows what he's talking about. He was in the middle of a gang shootout at another Chicago hospital ER. The shooting occurred while caregivers were trying to treat a gang member who had been shot on the street.

Even private offices aren't immune from violence. When Martin R. Sullivan, MD, a respected and well-liked plastic surgeon, was executed at his Wilmette private practice, health care professionals were reminded once again, that they are increasingly being drawn into a societal spasm of deadly aggression as a means of conflict resolution.

In a private clinic in May, Rockford urologist Donald P. Feeney, MD, was slashed by a patient who two weeks earlier sued Feeney for surgery the man claimed had left him "scarred and impotent." But the patient's family, including his former wife, said he had a history of violence and making threats against them, with alcohol contributing to the problem. Authorities also said he was diagnosed with manic-depressive disorder in 1988 but stopped taking his medication years ago.

HEALTH CARE PROFESSIONALS interviewed by *Illinois Medicine* agree that attacks on them are a symptom of the broader problem of societal violence. Fueling it is the ready access to handguns and other weapons; a crack cocaine epidemic that is growing faster in Chicago than in any other U.S. city, according to the *Chicago Tribune*; the failure to properly care for the mentally ill; and patients' unrealistic expectations of a system that frustrates health care providers as well.

The risks vary. Certainly, ER physicians and other medical staff are most likely to encounter daily violence. A 1992 American Hospital Association report on hospital security noted that assaults in emergency rooms accounted for 53 percent of all assaults reported in 1989, the latest year for which statistics are available. Assaults in psychiatric units, at 30 percent, were the second largest category.

Overcrowded ERs are particularly vulnerable to violence because long waits can make patients and visitors edgy and angry. In response, some institutions have begun using mechanical security measures such

VIOLENCE



Joe Hindley

as access-control and staff-identification devices, metal detectors, armed security officers, special training on handling violent and disruptive patients, emergency alarms and closed-circuit surveillance, according to the International Association for Healthcare Security and Safety.

In 1987, Henry Ford Hospital in Detroit was one of the first hospitals in the nation to install metal detectors at emergency department entrances. After 48 months and more than a half million screenings, nearly 17,000 hazardous objects, including about 10,000 knives and 600 guns, had been confiscated.

On the other hand, some institutions have resisted metal detectors and other devices because of concern about conveying a false sense of security or sending patients and visitors a negative message about the safety of the environment, according to the *Hospital Security and Safety Management* newsletter.

"Hospitals are unique facilities in that they are extremely accessible because of [compliance with] fire codes and other regulations," said V. James McLarney, director of the AHA's division of health facilities management. "And locked doors are the exception because hospitals are trying to be community-friendly. People are not questioned about their purpose, as they would be in another type of facility."

"One thing we don't want to do is turn medical settings into armed camps and environments where you feel as though you're visiting someone in jail," agreed Sidney Weissman, MD, director of the outpatient and emergency psychiatric programs at Loyola University Medical Center.

"I personally don't think there is a great witch-hunt against physicians in terms of violence," Dr. Winston said. "But we do need protective security. Access has to be controlled."

EVEN WHEN HEALTH CARE providers are not personally being targeted, there are signs that random individuals are taking the heat because of patients' disappointment in the health care system.

"There are those who have been disenfranchised from our system," said Ronnie W. Lee, MD, director of emergency medical services at Loyola. "We've gone from health care as a privilege to a perception of its being a right, yet the system does not bear that in mind. There is no way for us to divert that anger at the system."

Raymond E. Hoffmann, MD, a Rockford general surgeon and ISMS first vice president, said restricting patients might be "painting with too wide a brush. We don't always know who is who."

And although physicians could rely more on personal referrals from known patients and colleagues, metal detectors and other devices in private offices and clinics are "totally impractical," said Henry W. Lahmeyer, MD, a forensic psychiatrist at Northwestern Memorial Hospital.

Dr. Lahmeyer, who has interviewed victims and perpetrators of violence for 12 years, said people with "subclinical paranoia" are especially dangerous because they are able to function without others' noticing their problem. "They can plan, are often very bright, and can slip in and out easily," he said.

"We have to be aware of the interaction with

(Continued on page 16)

Violence

(Continued from page 15)

patients," said Dr. Weissman. "Do the patient's expectations become inappropriate? Is there something unusual going on in this interaction? Does the patient feel I'm incapable of doing something I should be doing? Is there some indication the patient is angry because I'm doing something that fosters expectations?"

Dr. Weissman also pointed out that physicians need to remind themselves of the very real phenomenon of transference by the patient, which can lead to unrealistic expectations, anger and violence. Dr. Winston and ER nurse Brown said conflict resolution and aggression management courses should be part of medical and nursing school curricula.

A PUSH FOR GUN CONTROL laws is a critical step, according to the Illinois Council Against Handgun Violence. Deaths from handguns are significantly higher in the United States than in other developed countries with strict gun control laws, said Willard A. Fry, MD, a member of the ICAHV's board of directors and senior staff physician at Evanston Hospital, where Dr. Sullivan had a staff appointment.

Dr. Fry also noted that the ICAHV is composed of volunteers. "We don't go out and buy votes the way the National Rifle Association does. I remember testifying in Springfield before a committee and seeing an official from Downstate snickering at us because we might want to change the gun laws. We just haven't tried hard enough."

Especially because of easy access to guns, physicians should be alert and aware in hospitals and private settings. "One general rule that seems to be accepted by all people working in the area of violence is that physicians who feel immune to attack – the ones who feel they are so good with patients, have such a good alliance and are sensitive individuals – are the most vulnerable. They feel unduly comfortable in their capacity to deflect violence," said Joseph Flaherty, MD, professor and deputy head of psychiatry at the University of Illinois at Chicago. "Never assume that things aren't going to be dangerous. If there is any question of a history of violence or drug abuse, see [those patients] with others present and see them in open rooms first." ■

Medicine calls for action against violence

ISMS policy regarding handguns, urges the legislature and the courts to "impose maximum penalties on all offenders." In 1992, the House of Delegates approved the Society's active involvement in the prosecution of those who assault physicians, including offering rewards for information leading to arrests.

After mail bombings that seriously injured two medical researchers, the AMA called on the federal government for action against violence directed at health care professionals. The organization demanded an immediate Justice Department investigation into those known to target physicians and researchers, requesting congressional hearings on violence against health care workers and the enactment of a "health care protection act."

A 1992 study in the *Journal of the American Medical Association* said that the typical American child will watch 8,000 murders and 100,000 acts of violence on TV before finishing elementary school. To help fight those statistics, in early August, the AMA endorsed the "Parental Empowerment and Television Violence Reduction Act of 1993," federal legislation that would require all television sets sold in the United States to be equipped with technology that allows parents to block out violent programming.

AMA President-elect Robert McAfee, MD, said, "Violence in the United States has reached epidemic proportions, and we cannot overlook that violence is a major medical and public health issue." ■

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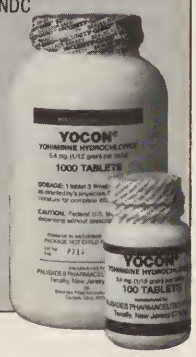
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Health care reform and the solo practitioner

With health care reform looming, solo practitioners are considering what the future holds.

BY GINA KIMMEY

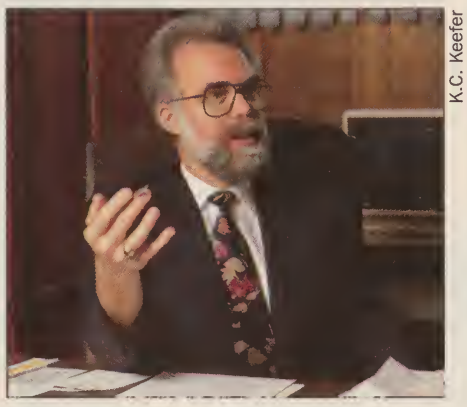
For months, physicians and patients alike have been awaiting President Clinton's health care reform proposal. More than four months after the first scheduled unveiling date, there is still no concrete plan. The insured, the uninsured and physicians who treat both, are wondering what reform will mean to them. From all indications, managed care and provider networks will have expanded roles in reformed health care. But how reform will affect the thousands of Illinois physicians currently in solo practice is still to be determined.

"I think the biggest change will deal with the word 'solo,' " said William E. Kobler, MD, a Rockford solo family physician and member of the ISMS ad hoc committee on health care reform. "I think we are going to lose [much] of our autonomy. As much as I hate to see it happen, I think that the days of practitioners who practice on their own are going to be fewer and fewer."

Dr. Kobler predicted that because of coming changes, physicians will have to link the business aspects of their practices for protection against larger health care entities and to help them negotiate fees and select practice arrangements.

Other physicians are concerned about the future of solo practitioners. "I'm concerned that in 10 years I will no longer be a solo practitioner," said William F. Hays, MD, a Herrin family physician. "I feel that I will probably be working for either a hospital or for some kind of health provider network. I think [many] of my freedoms of choice and my freedoms of how I choose to do business will evaporate with health care reform."

Not all solo physicians believe reform will significantly affect the way they practice, however. "I haven't seen anything concrete to indicate there will be a drastic change," said Arvind K. Goyal, MD, a Rolling Meadows family physician and ISMS immediate past president. Dr. Goyal said he doesn't think health care reform will pose any imminent threat to the way he treats patients.



K.C. Keefer

Dr. Kobler

"I believe the American public, my patients, are accustomed to receiving the best care. I don't think that will change," Dr. Goyal said. "Perhaps there will be more mandatory participation with other groups or alliances. I won't be able to refuse to work with them, but I will continue to provide the best service that I can." He said he believes that the president's proposal is based on too many optimistic projections and that it may result in only nominal reforms.

MANY PHYSICIANS ARE HOPING a reform plan will relieve, not worsen, the growing regulatory burdens that have recently plagued them. "All of us have noticed that the amount of regulation and paperwork we have to go through per patient has markedly escalated and that we have had to hire more people to help us deal with that," said Dr. Kobler. The additional staff doesn't increase his office's productivity; it just helps to keep up with the regulations, he noted.

"I get up every morning and spend probably a third of my day trying to figure out how not to get fined by the federal government, how not to get sued by patients and how not to do something wrong," Dr. Hays said. "We have become ineffective as a profession because we are bogged down with rules, regulations and paperwork. That's one of the primary reasons we need health care reform."

The government-imposed hassle factor can mean the difference between practicing paperwork and practicing medicine, Dr. Hays added. This is one area many physicians consider crucial in judging the success or failure of reform, he said. "I truly believe that if there is anything we can hope for, it is less regulation – to free me from regulatory burdens to where I can make decisions that are in the best interests of my patients without having to conform to a set of rules. Right now, we spend more time trying to shave the corners off a square peg to get it to fit into a round hole than we do actually taking care of the peg itself."

Solo practitioners are also concerned about the effect of reform on the physician-patient relationship, said Dr. Kobler. "I'm concerned that all the new arrangements are going to run the risk of putting more and more people between the doctor and his or her patients, and I think that we, at least those of us in primary care, feel that [the physician-patient relationship] is the real basis for where medicine is at.

"Physicians need to think very hard about the alliances they form and the contracts they sign," he continued. "Look at it from all sides and consider not only what it means initially, but what it might mean in the future." He said he encourages physicians to get involved only with organizations that offer them a considerable say in the operation's governance. Physicians accustomed to practicing on their own should be careful to avoid ending up as employees who are "at the mercy and whim of their employer."

Many physicians, including Dr. Goyal, have already been approached to sign on with HMOs and managed care plans. "The day I find an ideal contract, where

(Continued on page 22)

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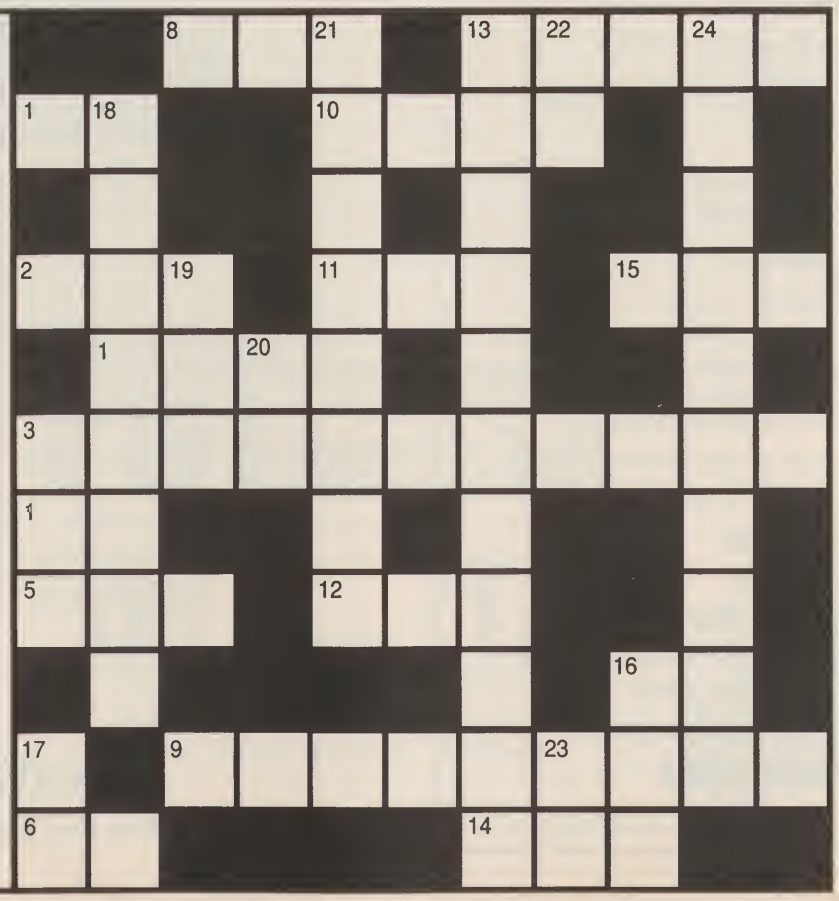
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19. Golfer's delight
20. Candela
21. Complete performance
22. Wagon's ____ (How Doc Went West)
23. ____ and behold!
24. Tissue connector



Illinois Medicine *asked people on Michigan Avenue in Chicago,*

The last time you saw your physician, what preventive health measures did he or she discuss?



Michael Brooks
Supervisor
Pittsburgh

My doctors really haven't said too much. They haven't said anything about weight. Some people do have a weight problem, but they're embarrassed to ask questions. Talking about weight would be something doctors could do to help patients out.



Emily Birdsong
Floral delivery driver and artist
Minneapolis

The last time I saw a doctor was a naturopathic doctor. In recent times, my doctor advised me to stop drinking so much coffee because my heart beats too fast sometimes. They definitely should discuss preventive measures with patients.



Bill McGuire
Illustrator
Chicago

Nothing really. I just had a general checkup. I talked about cholesterol. He did a cholesterol check, and it was low. I think up to a point physicians should probably discuss things to help you stay healthy rather than just check up and see if you're all right and then let you go.



Lise Olsen
Certified nurse practitioner
Chicago

I brought the subject up myself, but I think my doctor would have done it if I hadn't. She struck me as being a really careful practitioner. We both discussed how important preventive health care is. She simply asked me if my lab work and my X-rays, Pap smear and mammogram were up to date. I was able to tell her exactly when I had everything done. Patients should absolutely take responsibility for their own health care.

Photos by Michael Candee

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Medical school

(Continued from page 1)

recession, people traditionally go back to school. The '80s are over. People are unhappy producing for the corporate bottom line." She also said people are more interested in helping others. "Everyone is concerned about health care in some way."

Prospective students submitted 8,009 applications for 130 openings in this year's freshman class at the Loyola University Stritch School of Medicine, said spokesperson Jackie Lasota. In addition, Loyola has already received 2,568 applications for the class that will enroll in 1994 – 720 more than were received at this time last year, Lasota said. Overall, the school has seen marked increases for the last three years, receiving 5,300 applications in 1991 and 6,300 applications in 1992.

"I'm rather surprised, with all the talk of [health care reform], that so many people still consider medicine a good career choice," said William Wallace, UIC College of Medicine dean of student affairs. UIC applications have increased 72 percent in the past three years, and the college received a record 5,684 applications for 300 slots in the class that began medical school last month. "Despite the uncertainty of managed care, people are still interested in the things medicine has to offer, like its scientific nature and the human aspects. In medicine, there is still the ability to make a significant impact on people's lives," said Wallace.

DESPITE RECENT CRITICISMS that too many physicians – particularly subspecialists – are entering the work force, Wallace said he does not think medical schools will significantly expand their programs to accommodate the larger applicant pools. However, UIC is encouraging students to choose primary care specialties, he noted.

At UIC, Illinois residents make up 90 percent of each incoming class. In 1992, applications from non-Illinois residents alone exceeded the total applications submitted in 1991. Southern Illinois University School of Medicine's student body also includes mainly Illinois residents. "We set a record last year and struggled to process all the applications," said Erin Coil, SIU School of Medicine director of admissions. "There are even more this year."

SIU received 1,733 applications in 1993, nearly twice as many as were submitted in 1990, Coil said. The previous application record was set in 1972 – the school's first year – when 1,458 students applied for admission. "Medicine is thought to be very stable against the economy," Coil said. "Everyone gets a good, well-paying job. But there are easier ways to make a lot of money. We're trying to take people who want to help people." Medicine will also remain popular because "people are proud to be in a helping profession."

Wallace predicted that medical school applicants may not realize that they are attracted to a profession that could be markedly different in the next 10 to 20 years. They are interested in medicine "the way it is today or has been, not the way it will be in the future." ■

Flood cleanup

(Continued from page 5)

bat infestation caused by large-scale standing water. To date, more than 3,300 DPT immunizations have been given to flood fighters. The medical society recently sent letters to Quincy-area pharmaceutical companies, requesting donations for the fund. Donations may be sent to the Adams County Medical Society Health Aid '93 Fund, 2039 Sunnybrook, P.O. Box 767, Quincy, IL 62306.

To facilitate the cleanup, the Illinois Environmental Protection Agency has established waste-collection centers for flood debris. A mobile heavy-duty trash compactor operated by the Illinois Department of Transportation will stop at these sites. The state intends to help citizens dispose of flood waste in environmentally sound ways, said Gov. Jim Edgar. "I urge people, as they begin to clean up from this disastrous flooding, to take their ruined tires, refrigerators, washers, driers and household chemicals to one of the drop-off sites," the governor said.

Three categories of waste – metal appliances, tires and household hazardous waste – will be accepted at the collection centers. Household hazardous waste includes used motor oil, paint and paint thinners, and other household chemicals. Commercial and industrial hazardous waste will not be accepted.

The IEPA is also offering a fact sheet, "When the Cleanup Begins," that details the best ways to dispose of flood-related waste products and debris, such as propane tanks, drums of unknown materials, furniture, household chemicals and sandbags. To obtain a fact sheet or find the nearest waste collection center, contact the IEPA public information office at (217) 782-5562. ■



Drug misuse

(Continued from page 1)

National Institute on Drug Abuse, researchers found that approximately 12 million Americans abuse prescription drugs. The survey defined abuse as use of drugs without a prescription, in greater amounts than prescribed, more often than prescribed or for any reasons other than those given by a doctor.

Because of concern about drug misuse by the elderly, IDA and the Illinois Council on Aging developed a brochure, "Personal Medications Record," to help senior citizens and their health care providers monitor their prescriptions, said Jan Costello, IDA spokesperson. "The basic problem is that older people take many medications and often see more than one doctor. Physicians may not know what other physicians are prescribing [for] the same patient."

IDA is working with the Illinois Pharmacy Association to distribute the brochure to pharmacies and health care facilities statewide. The brochure provides spaces for patients to list all their physicians and pharmacists. In addition, it includes an outline so that patients can create a master medication list noting each medication, its purpose, its color and shape, the date they started taking it, the dosage and frequency, the date they completed the prescription and the name of the prescribing physician.

"This is a very important issue," said Joanne G. Schwartzberg, MD, immediate past president of the Illinois Geriatric Society and director of the AMA's department of geriatric health. "We need a lot of consciousness-raising so that people can realize the consequences of misuse of prescription drugs."

ISMS' PARTNERS FOR HEALTH PROGRAM for seniors includes a Personal Health Record, in which patients and physicians can list "vital statistics" such as patients' blood type, allergies and vaccinations. The booklet also includes spaces for noting new and current prescriptions.

"It's a wonderful little booklet," Dr. Schwartzberg said. "But it's sometimes hard for patients to remember to bring it back. Physicians really have to make an effort to get patients to remember."

Dr. Schwartzberg said that although seniors make up about 13 percent of the U.S. population, they use 30 percent of all prescription medication and 70 percent of all over-the-counter drugs. She cited U.S. Food and Drug Administration findings that 55 percent of older adults fail to comply with physician instructions for taking prescription medications. "That's a lot," she said, adding that reasons for noncompliance vary from forgetfulness to discontinuation because they feel better.

Prescriptions are written during two-thirds of all office visits, so the extent of misuse can be serious, Dr. Schwartzberg said. "Ten percent of hospital admissions of patients over 65 are for noncompliance."

Often older patients are reluctant to ask questions about how to properly take their medications, exacerbating noncompliance problems, Dr. Schwartzberg said. "We need to create dialogue with patients about medications. Patients sometimes don't tell their physicians what drugs they're already taking. They end up doubling and can get into serious trouble.

"The [American Association of Retired Persons] and other senior groups are finding it an uphill battle to get patients to ask questions," she continued. "And physicians are finding it difficult to take what patients say on face value." She explained that patients aren't trying to deceive physicians about their medications, but they don't always understand that although two drugs have different names, they may do the same thing. Consequently, physicians must take great care to explain that patients must tell them every drug they are using, even if it seems insignificant.

"Older patients often see more than one physician," Dr. Schwartzberg said. To avoid duplicating prescriptions, she recommends that older patients and their primary care physicians conduct "brown bag" medicine reviews during which patients bring all of their medications to the office for their doctor to evaluate. The primary care physician then creates a list that the patients' other physicians can consult.

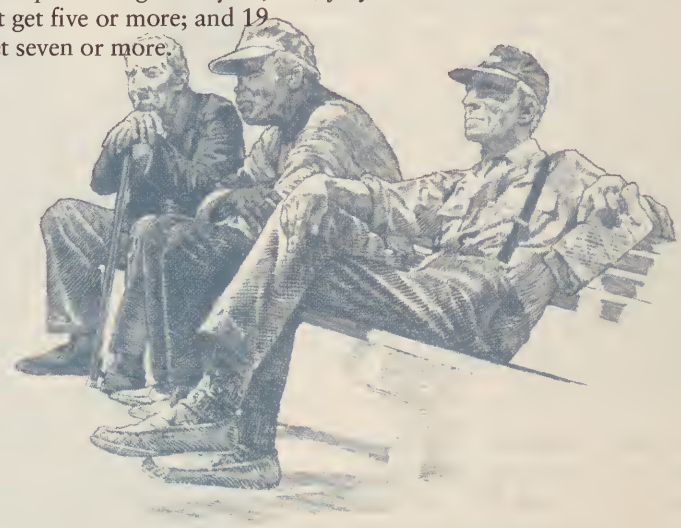
In "Drug Prescribing for the Elderly," an article published in the December 1986 issue of *Archives of Internal Medicine*, author Avorn J. Everitt, MD, noted: "Given the vulnerability of the elderly patient to adverse drug effects and the frequency of their occurrence ... it is incumbent on the physician to conduct periodic reviews of the drug regimen for each patient. This approach is especially productive when combined with a 'brown bag session' in which the patient is urged to bring in for re-evaluation all medications he or she is taking from all providers, including over-the-counter preparations." ■

Facts about prescription use in the elderly

At the Ninth National Conference on Prescription Medicine Information and Education held in May in Washington, D.C., the following statistics were presented:

- Approximately 90 percent of Americans aged 60 or older – 35.5 million people – take one or more medications.
- The average elderly outpatient uses two to four different prescription drugs at one time.
- Among individuals aged 65 to 84 who live in the community – not in hospitals or nursing homes – 61 percent receive three or more different prescription drugs in a year; 37 percent get five or more; and 19 percent get seven or more.
- Each year, more than 9 million adverse drug reactions occur in older Americans.
- Unwanted side effects of drugs are seven times more common in the elderly than in younger adults. In 1985, adverse reactions to drugs caused an estimated 243,000 adults aged 60 or older to be admitted to hospitals.
- Nearly one-fourth of all nursing home admissions are prompted by seniors' inability to take their medicines properly.

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"Just What The Doctors Ordered"



Solo practitioner

(Continued from page 19)

they are not just concerned with cutting corners and saving money, but also ensuring quality care, then I will sign," said Dr. Goyal. "I can't say that cheaper care can't be better care, but I haven't seen it yet."

PHYSICIANS AND THEIR PATIENTS want health care reform to ensure better access and high-quality care, said Dr. Hays. "I think people want to know when they go into the operating room or the doctor's office or the hospital that they are going to receive quality care. It's an area where we as physicians have to be patient advocates."

"I think the health care we get for our dollar is still the best in the world," said Dr. Kobler. "Many of our costs are due to nonmedical, social kinds of problems. I would like to see those things improve and yet still maintain the sanctity of the physician-patient relationship. That would be the one thing that I would like to see really sustained or even improved – the closeness between the doctor and the patient." ■

IDPH budget

(Continued from page 1)

last year's $376.5 million appropriation. He included key issues that were adopted by the General Assembly."

Before adjourning July 13, the legislature appropriated $427.8 million for the department, $100.7 million of which are state general revenue funds. As requested by Edgar, the budget for AIDS programs was raised by $3.6 million – a 100-percent increase. This is the first increase in AIDS program funding in four years, according to the AIDS Foundation of Chicago.

AIDS FUNDING will be directed to three areas, including expanded drug reimbursement for AIDS patients, Robinson said. Eligibility for the drug reimbursement program will be broadened to include patients with incomes at 400 percent of the federal poverty level; the current eligibility level is 200 percent. AIDS counseling and testing programs will also be increased at STD clinics statewide, with an emphasis on identifying possible risk factors as part of family planning and prenatal care. Finally, AIDS education will be stressed more, Robinson said.

IDPH was allocated $10 million – Edgar's requested amount – to provide case management services to certain medically indigent children and pregnant women through the Healthy Moms/Healthy Kids program. "We'll be able to direct people to more services," Robinson said. The joint venture between IDPH and the Illinois Department of Public Aid is funded primarily through the public aid budget. IDPA received $52.7 million in state funding for the program, $28.5 million less than had been expected, according to Greg Rexroad, an IDPA spokesperson.

IDPH'S TOTAL BUDGET appropriation for fiscal '94 is $15.7 million more than the governor had proposed, Robinson said. Of those additional funds, $7 million will come from general revenues. The increase stemmed from several add-ons approved by the General Assembly, including $1.2 million to fund rural health programs, he said. "The rural health appropriations will have a dramatic effect on these programs," Dr. Lumpkin said. The General Assembly also allocated an additional $800,000 to fund rural health programs at Southern Illinois University School of Medicine and UIC College of Medicine at Rockford.

Another $500,000 was allocated to the Illinois Coalition Against Sexual Assault for operation of rape crisis centers throughout the state. The group currently receives $1.5 million but successfully lobbied for more funding, Robinson noted.

Alzheimer's disease and breast and cervical cancer programs are also funded in the new budget, receiving $265,000 and $250,000, respectively. The Alzheimer's allocation will be used to help fund two treatment centers, located at Rush-Presbyterian-St. Luke's Medical Center in Chicago and Southern Illinois University School of Medicine in Springfield.

Most of the added-on funds are earmarked to consolidate city of Chicago public health laboratories with state labs. The legislature appropriated $5.1 million to help IDPH assume responsibility for operating the facilities. "It is a more efficient way of providing lab services," Robinson explained. "Formerly, lab services were paid for by local dollars." Although the consolidation will increase the efficiency in delivering lab tests, it will not create or expand services, he noted.

In addition to the increases, the department's operational line items were cut by nearly $400,000, Robinson said. "This will have a moderate effect upon the department. We'll have to do some belt-tightening."

Given Illinois' fiscal constraints, competition for state general revenue dollars has intensified. However, most of the state's public health budget is derived from federal funding. Since the federal fiscal year begins Oct. 1, the department can currently only estimate the funding it will receive from Washington. "We don't know what the awards will be," Robinson said. "We have to budget ahead in order to spend future funds more efficiently." Nevertheless, IDPH anticipates federal funding increases for immunization initiatives, AIDS programs under the Ryan White Care Act and lead screening. ■



Wm. Daniels/The Photo Partners

Dr. Lumpkin

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosponne. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli;* a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae.* In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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THE PRAVACHOL® DIRECTION
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Effective lipid management doesn't have to be tough

- Improves key lipids — significant reduction in LDL-C[1]
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pravastatin sodium 20 mg tablets

PRAVACHOL is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

Active liver disease or unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin sodium.

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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RETENTION GROUPS TOO RISKY? (PAGE 6)

SEPTEMBER IS WOMEN IN MEDICINE MONTH

PAGE 2

Illinois Medicine

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Chicago physicians aim to stop the killing

PAGE 9

Governor signs health-related bills

LEGISLATION: Bills of interest to physicians are now on the books. By Anna Brown

[SPRINGFIELD] Since the spring legislative session ended July 13, Gov. Jim Edgar has signed several bills of interest to physicians. Overall, the General Assembly acted on about 270 such bills during the session.

On Aug. 20, the governor signed an anti-smoking bill. Now law, H.B. 1576 prevents children's access to tobacco products by authorizing state inspections of retail tobacco distributors and by levying fines for violators. The bill was sponsored in the Senate by Sen. Doris Karpiel (R-Roselle). In addition, as part of the budget, a 14-cent-per-pack tax increase on cigarettes was approved by Edgar. ISMS supported H.B. 1576 and the five other unsuccessful anti-tobacco measures sponsored by Rep. John Dunn (D-Decatur).



Gov. Edgar

Signed Aug. 12, amended H.B. 2242 calls for the Illinois Department of Public Aid to study an electronic health information system for processing Medicaid claims and records. Bill sponsor Rep. Jeffrey Schoenberg (D-Wilmette) said the study might culminate in the use of health care cards with electronic microchips or electronic strips containing patient information. The "smart cards" would help process Medicaid claims and would result in substantial savings for the state and taxpayers, he said.

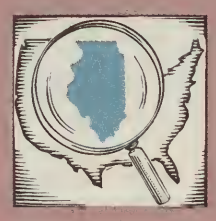
The governor signed S.B. 66 Aug. 20. Sponsored by Sen. Judy Baar Topinka (R-North Riverside) and Rep. Joseph Kotlarz Jr. (D-Chicago), the measure amends the Alternative Health Care Delivery Act by adding postsurgical recovery care centers as authorized alternative health care delivery models. The Act requires facilities to be licensed as ambulatory surgical treatment centers or hospitals for at least two years before participating as pilot

(Continued on page 15)

INSIDE

State 'partnership policy' to aid elderly

PAGE 3



Illicit drug use declining

PAGE 2

Planning board holds credentialing hearings

PAGE 2

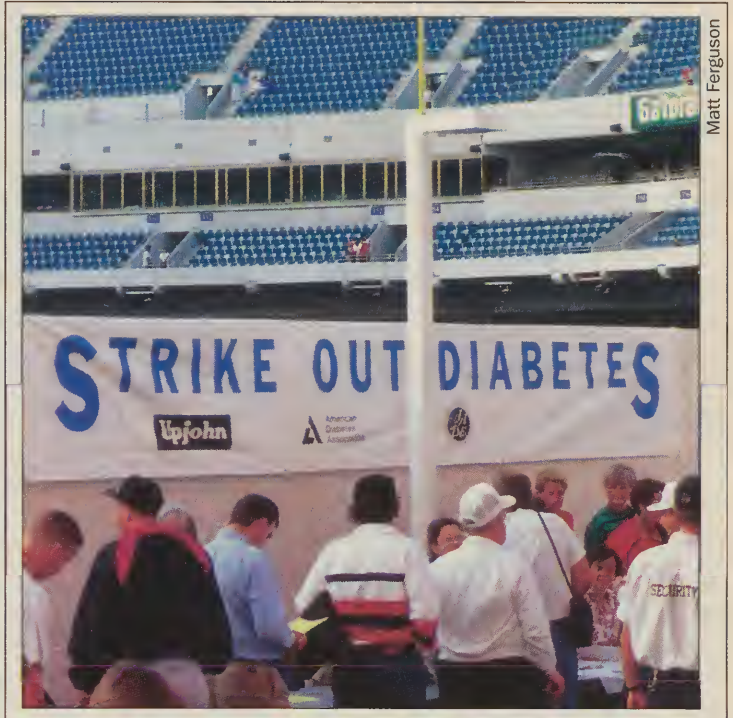
DEPARTMENTS

News Briefs.....2

Commentary.....4

ISMIE Update.....6

Classifieds 13



Matt Ferguson

IN ADDITION TO seeing a first-place team, fans attending the Sept. 8 Chicago White Sox game participate in Strike Out Diabetes Night by completing American Diabetes Association risk assessment questionnaires.

Funding for mental health programs remains stable

BUDGET: Mental health department will build on existing programs. By Anna Brown

[SPRINGFIELD] The Illinois Department of Mental Health and Developmental Disabilities will use its fiscal 1994 budget appropriations to begin easing patients from state facilities into community-based programs. This transfer will improve staff-to-patient ratios and services in state facilities, department officials said.



The department received $936.7 million in general revenue funds in the budget signed by Gov. Jim Edgar in July. In addition to general revenue funds, the department's total budget of $995.9 million includes a $7.5 million federal project fund, $13.4 million in federal mental health block grants and a $13 million state mental health fund, according to Lynn Handy, the department's management and budget director.

"This is a much more stable year for us," Handy said. "In fiscal 1993, we had a lot of layoffs based on the budget passed [last] spring. We had proposed some bed reductions and supported some shifting of funds, but not at the fiscal '93 level. We got through it well, but it was very difficult."

This year, the number of state-operated beds had to be

(Continued on page 15)

Medicare to reimburse for flu shots

PREVENTIVE CARE: A federal study shows influenza vaccinations for the elderly prevent some forms of pneumonia. By Anna Brown

[ATLANTA] Federal health officials announced Aug. 12 that flu shots will be covered for Medicare Part B patients beginning this fall. The decision to cover the inoculations was made after results of a four-year study showed a correlation between flu shots for seniors and lower rates of flu-related pneumonia. According to U.S. Centers for Disease Control and Prevention officials, the federally mandated study was commissioned to help justify Medicare reimbursement for preventive health care services.

"The study looked at the ability and related cost savings of influenza vaccine in preventing pneumonia during flu season," said Ray Strikas, MD, a CDC immunization specialist. The vaccine was found to be effective in preventing direct viral and secondary bacterial pneumonia in seniors who received flu shots. However, the study failed to determine conclusively whether Medicare would save money by covering flu vaccinations as a Part B benefit.

In commissioning the study, Congress said the vaccine would be covered by Medicare even if research failed to prove that paying for the shots would ultimately save money, Dr. Strikas said. "The legislation was written to say that if [the study] could not prove a negative, the vaccine would be covered."

The study results regarding the cost-effec-

(Continued on page 11)

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H.B. 1852 outlines new rules for surgi-centers

[SPRINGFIELD] Illinois physicians who perform surgery in their offices should be aware of a recent change in the Ambulatory Surgical Treatment Center Act. When Gov. Jim Edgar signed H.B. 1852 this summer, the Act was amended to include the following: "A person or facility not licensed under this Act or the Hospital Licensing Act shall not hold itself out to the public as a 'surgery center' or as a 'center for surgery.'"

Under the new law, physicians who currently perform in-office surgery but who are not licensed under either Act may advertise these services, but they may not refer to their practice as a "surgery center" or as a "center for surgery," according to ISMS legal counsel. Physicians who have questions about the new amendment can contact the ISMS medical services department at (312) 782-1654 or (800) 782-ISMS. ■

$10 million provided to fight tobacco use

[PRINCETON, NJ] As many as 18 statewide coalitions will receive grants totaling $10 million from the Robert Wood Johnson Foundation's new "Smokeless States" program. The funds will be used to develop and implement education, treatment and policy programs to fight preventable smoking-related deaths in the United States.

"It is alarming that virtually no progress has been made in reducing teen tobacco use, and the nation, as a whole, has not taken action to reduce tobacco consumption," said Steven A. Schroeder, MD, foundation president. "This program is intended to strengthen state resources and enable community and regional groups to carry out comprehensive and highly visible tobacco prevention and control initiatives."

Applications will be accepted for two types of grants: two-year grants of up to $200,000 and four-year grants of between $500,000 and $1.2 million. Only one application will be accepted from each state. The AMA has been awarded an additional grant to provide assistance and direction to applicants and recipients. Thomas P. Houston, MD, director of the AMA's department of preventive medicine and public health, will serve as national program director.

"Tobacco is the No. 1 preventable cause of death and disease in the United States, accounting for more than half a million deaths each year and billions of dollars in health care cost," said James S. Todd, MD, AMA executive vice president. "The physicians of this country are committed to reducing the high number of senseless deaths caused by tobacco."

Grant recipients will be expected to launch public education campaigns, improve their states' capacity to provide tobacco prevention and treatment programs, and develop and promote a policy agenda that would reduce tobacco use, such as increasing tobacco excise taxes. A one-day workshop for potential applicants is tentatively scheduled for Oct. 15 in Chicago. For more information about the workshop, contact Dr. Houston at the AMA, 515 N. State St., Chicago, IL 60610; or call (312) 464-5957. ■

Planning board holds credentialing hearings

The Illinois Health Facilities Planning Board will conduct public hearings on economic credentialing in October. The hearings will take place from 1:30 p.m. to 5 p.m. at the following locations:



Oct. 7
Illinois Department of Public Health
525 W. Jefferson, Fourth Floor
Springfield

Oct. 26
Executive Plaza Hotel
71 E. Wacker Drive
Chicago

The public meetings are in conjunction with a study of economic credentialing being conducted by the planning board, as directed by the Illinois General Assembly. ISMS members should take advantage of this opportunity to provide information.

For more information, physicians may contact Ray Passeri, Division of Facilities Development, Illinois Health Facilities Planning Board, 525 W. Jefferson, Second Floor, Springfield, IL 62761; or (217) 782-3516.

Illicit drug use declining

[SPRINGFIELD] A survey conducted by the National Institute on Drug Abuse shows a decline in illicit drug use in most categories since 1979. Illinois Lt. Gov. Bob Kustra, who coordinates the state's efforts against substance abuse, called the results encouraging, but said the nation has much more to do.

"This survey shows that messages about the dangers of substance abuse are being heard and heeded, but millions more must be reached," Kustra said. "Illicit drug use is on a steady decline – from 24 million illicit drug users in 1979 to 11.4 million today. While heavy drinking is a continuing problem, alcohol use by minors dropped 38 percent from 1988 to 1992. This survey shows that our efforts to educate young people about the risk of substance abuse is working, and those prevention efforts must continue."

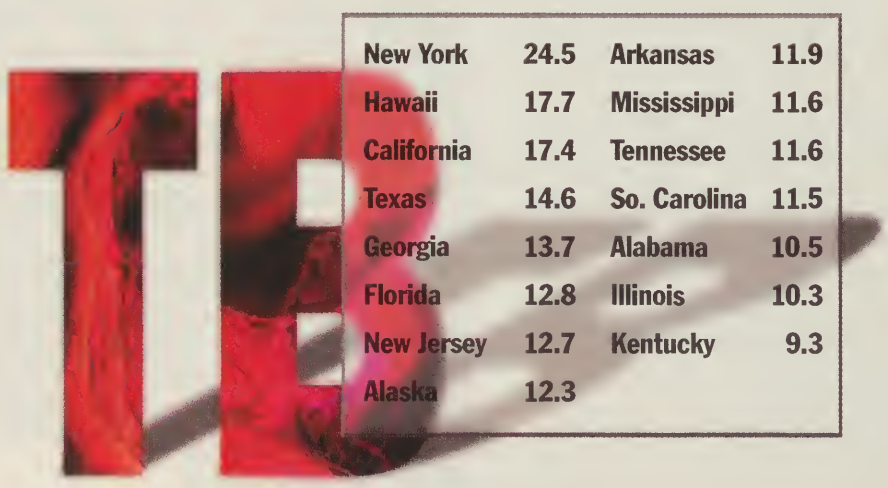
Although survey results were generally positive, a few specific problem areas were noted. Drug use among Americans age 35 or older has increased, a trend that experts believe may be affected by the aging of those who used drugs during the 1970s. Rates of illicit drug and heavy alcohol use continue to be highest among those with the least amount of formal education. The survey also showed no decline in the number of frequent users of cocaine. On the other hand, the number of occasional users has continued to decline, from 4.3 million in 1991 to 3.4 million in 1992.

Kustra said he hopes the survey results will renew the strength of those waging the battle against drugs. To continue its community-based prevention system, the Illinois Department of Alcoholism and Substance Abuse has applied for a $5 million federal grant to increase the availability of drug treatment services in Chicago. ■

PHYSICIAN FACTS

Tuberculosis is back

The following shows the 15 states with the highest TB rates per 100,000 residents*:



New York	24.5	Arkansas	11.9
Hawaii	17.7	Mississippi	11.6
California	17.4	Tennessee	11.6
Texas	14.6	So. Carolina	11.5
Georgia	13.7	Alabama	10.5
Florida	12.8	Illinois	10.3
New Jersey	12.7	Kentucky	9.3
Alaska	12.3		

Source: U.S. Centers for Disease Control and Prevention
* Rates are based on 1991 population figures.

Facts on women physicians

To mark Women in Medicine Month in September, the AMA released the following information about women physicians:

NUMBER OF WOMEN PHYSICIANS

- In the past 20 years, the number of women physicians in the United States has tripled, from 35,636 in 1975 to 118,500 in 1992.
- By 2010, women physicians will make up more than 30 percent of the physician population.
- Seventy-two percent of women physicians are under age 44. Fifty percent of male physicians are between the ages of 35 and 54.
- In 1992, 51 percent of women and 61 percent of men worked in office-based practices.

MEDICAL EDUCATION

- Forty-two percent of all medical students are women.
- Of the 15,554 students expected to graduate from medical school in 1993, 38 percent are women.
- Over the past 20 years, the number of women enrolled in medical school has increased from 6,099 to 25,933.
- From 1991 through 1992, women held 22 percent of all full-time medical faculty positions. However, only 9.5 percent of these full-time female faculty members held full professorships.
- Currently there are two female U.S. medical school deans.

SPECIALTIES

- Women physicians are three times more likely to be pediatricians than are male physicians.
- Between 1980 and 1992, most women physicians elected to specialize in internal medicine. Forty percent chose pediatrics as their specialty.
- Of the 26,000 female resident physicians in training in September 1991, one-third worked in internal medicine or pediatrics. Another 26 percent were training in Ob/Gyn, family practice or psychiatry.

WORK HOURS

- Female physicians work about 10 percent fewer hours per year than their male counterparts.

INCOME

- Female physicians earn 59 percent to 63 percent less than male physicians.
- Differences in income for female and male physicians are less per visit than per hour, indicating that female physicians may schedule fewer patients per hour.

AMA MEMBERSHIP

- The number of women physicians who are AMA members increased from 13,328 in 1980 to 33,236 in 1991. ■

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State 'partnership policy' to aid elderly

INSURANCE: A new public-private long-term care insurance plan should help seniors protect their savings while receiving care. By Anna Brown

[EVANSTON] The last in a series of public hearings on the state's proposed Long-Term Care Partnership Insurance Policy was held Aug. 27 at the Evanston Civic Center. As planned, the pilot insurance program would allow seniors receiving long-term care to protect part or all of their assets after their insurance benefits are depleted. The program was mandated by the General Assembly as a partial solution to the growing long-term care funding crisis in Illinois. According to lawmakers, the state's Medicaid program is the "insurer of last resort for increasing numbers of middle-income Illinoisans."

Slated for implementation by July 1994, the project was developed by a 34-member task force composed of insurance industry representatives, consumers and state officials. The governor's office, in conjunction with the Illinois Department on Aging and the Illinois Department of Insurance, conducted seven public meetings statewide to explain specifics of the program to senior citizens. Also attending were legislators representing the districts where the hearings were held.

"The long-term insurance care plan crafted by the task force I appointed in March will give consumers the opportunity to receive a unique blend of insurance coverage and asset protection not available through traditional coverage," said Gov. Jim Edgar in announcing the hearings.

Under the proposed partnership program, Illinois seniors would be able to purchase long-term care insurance that covered any portion of their assets they wished to protect. When those policy benefits were expended, seniors would immediately qualify for Medicaid. Standard long-term care insurance requires individuals to use their own resources before turning to the state for help.

The partnership program would also allow seniors to purchase policies for less than the total amount of their assets. Then, after the benefits were depleted and seniors had paid the difference between the amount of the policy and the amount of their personal assets, they would qualify for state assistance.

At the Evanston meeting, IDA Director Maralee Lindley explained that the plan is called a "partnership" because it was developed through a public-private venture between the state and insurance companies approved by the state to sell the policy. Insurance agents from those companies would be specially trained in the intricacies of long-term care and the partnership policy. New York, Connecticut, Indiana and California already offer such programs, Lindley said.

The General Assembly passed the Health Care Partnership for Long-Term Care Act in 1991, creating the pilot project, said C. Jean Blazer, a psychologist with IDA. A benefit of the partnership program is increased emphasis on home- and community-based care, Blazer said. Most long-term care insurance policies limit services to nursing home care. By covering such services as shopping, laundry, transportation to medical services, home-delivered meals and daytime supervision, the new program would give seniors more flexibility in choosing the type of care they receive, she said. Case management services would also be covered.

Services that allow patients to remain in their own homes are significantly more cost-effective than nursing home care, Blazer said. Patients who use these home-based services can extend their insurance benefits. Also, unlike standard policies, "the more prudently the benefit is used, the longer it will last," she added.

The program would also feature more flexible eligibility requirements. For example, there would be no age limits for purchasing a policy. Eligibility for insurance benefits would be determined by the local agencies that currently make eligibility decisions for long-term care services under Medicaid. Policyholders would also have the right to appeal eligibility decisions to the state, Blazer said.

She cautioned, however, that regulations in the new federal budget may affect the program's implementation. Although the specifics of the new regulations outlined in the budget have not yet been fully analyzed, Blazer said the state is still planning to proceed with the program. She said she expects some modifications may be necessary. "There is a strong possibility that the federal law will change our plans." ■

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REPORT FOR *Illinois Physicians*

"OFF-LABEL" USE OF ANTI-CANCER DRUGS
ILLINOIS PUBLIC ACT 87-980

Illinois Public Act 87-980, which addresses insurance coverage for the so-called *"off-label"* use of anti-cancer drugs, went into effect on 1/1/93. This law requires that health insurance coverage, to the full extent that drugs in general are covered in a particular health insurance policy, must be applied to any drug which has been approved by the FDA for the treatment of a certain type of cancer, even if the drug is used in the treatment of a cancer which is different than the specific cancer for which the FDA approved the use of the drug. This is significant because Blue Cross and Blue Shield of Illinois (BCBSI), like other health insurance carriers, denies coverage for the use of *"experimental"* or *"investigational"* therapies; for drug therapy, FDA approval of a drug for the treatment of a specific condition has been considered necessary for that drug to be considered non-investigational in the treatment of that condition, and therefore eligible for coverage. However, under the new law, coverage is extended for the use of an FDA approved anti-cancer drug, even when that drug is used in the treatment of non-approved cancers, a situation that otherwise would have been deemed *"experimental"* by BCBSI and not eligible for coverage. An additional requirement for coverage is that the drug must be mentioned as being useful for the treatment of the specific cancer (albeit not the FDA approved use) for which it has been prescribed, by at least one of the following drug evaluation publications:

- AMA Drug Evaluations
- American Hospital Formulary Service Drug Information
- U.S. Pharmacopeia Drug Information
- At least two (2) separate clinical studies published in peer review journals.

The new law does not require coverage if the FDA still considers the drug to be basically experimental or investigational, or if the FDA has determined that the drug is definitely contraindicated for the treatment of the cancer in question.

Coverage is also mandated for all medically necessary services associated with the administration of the drug.

Once again, this new legislation applies only to anti-cancer drugs.

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EDITORIAL

Some good press on student loan repayment

Doctors have recently received some bad press over student loan default figures published for the first time in the *Federal Register.* The publication printed a list of doctors, dentists and other health care professionals who defaulted on federal student loans, which included their business addresses and names of medical schools they attended. Out of the thousands of MDs practicing in Illinois, only 66 were listed. Of those 66, only six are ISMS members.

The Illinois Department of Professional Regulation licenses more than 600,000 people in 44 occupations, according to a recent story in the *St. Louis Post-Dispatch.* IDPR does not renew licenses of individuals who owe the state money for student loans. These include – among others – architects, cosmetologists and social workers, as well as doctors and other health care professionals. Of course, borrowers, regardless of their profession, should repay student loans. Yet even though people other than physicians have a higher default rate, it's usually the physicians who get the headlines.

What about the good press? In 1983, ISMS began making loans to third- and fourth-year medical students. Since then, 612 loans have been issued for a total amount of $1,250,011; 104 loans have been repaid; and 50 are in the process of being repaid. The ISMS program has a low default rate: Only two borrowers have defaulted, and one is currently repaying the loan.

Payment on the ISMS loans is not due until students have completed all of their medical education, including internships and residencies. The loans have no strings attached and do not require students to practice in any particular areas after graduation or to repay the loan with any kind of service. The only requirements are that candidates be enrolled in Illinois medical schools, be designated financial aid recipients by their schools and pledge to become ISMS student members.

Students can even apply for extensions on their ISMS student loans if they enroll in more educational programs after graduation. The Committee on Financial Aid to Medical Students evaluates the merits of each case and grants extensions accordingly.

The program's success may be partly due to the fact that its administrators keep in constant communication with students, following them even through the students' frequent moves. But the program may also be successful because there are responsible doctors out there who work at repaying their student loans. It's too bad we don't hear more about them.

PRESIDENT'S LETTER

Caps are the cornerstone of tort reform

By Arthur R. Traugott, MD



Proposing reform that does not include caps demonstrates a shallow commitment toward correcting the tort system.

Now, more than ever, physicians must marshal their resources and convince lawmakers of the need to enact caps on noneconomic damage awards. Since President Clinton left this piece out of his tort reform puzzle, it is now up to the states to set reasonable limits on pain and suffering judgments.

Although Clinton is reportedly considering some tort reforms, such as caps on lawyers' contingency fees, certificate of merit requirements, nonbinding dispute resolution and collateral source rules, he appears to have decided against caps on noneconomic awards at the federal level. Unfortunately, proposing reform that does not include caps demonstrates a shallow commitment toward correcting the tort system. Without capping noneconomic damages, tort reform cannot fully succeed in helping lower health care costs and alleviating the need for physicians to practice defensive medicine. Nor can alternative dispute resolution work without incentives to settle outside of court.

Here in Illinois, we've already enacted the reforms Clinton is proposing. During the ISMS Professional Liability Initiative of 1985, Illinois physicians launched an all-out campaign in the state Capitol for comprehensive tort reforms. And we were successful. The General Assembly passed legislation abolishing punitive damages, establishing provisions for structured verdicts, requiring certificates of merit for filing suits and limiting attorneys' contingency fees. In the eight years the reforms have been in effect, we've seen stability in the frequency of claims in Illinois – particularly the frequency of nonmeritorious suits. In fact, from 1991 to 1992, the number of claims reported to ISMIE increased only 2.7 percent. This leveling off of claims frequency is consistent across all specialties. So we are making some headway.

But at the same time, the severity of awards has been steadily climbing. For example, ISMIE's average payout from 1990 to 1992 rose from $262,510 to $344,881. And this is why caps are so necessary. Without establishing these limits, awards will continue to rise.

But the battle for caps is fought against the plaintiff lawyers who continue to promote the misconception that caps would deny injured patients of just compensation. Nothing is further from the truth. Even with caps in place, those truly harmed through malpractice would still be entitled to fair compensation for their economic losses and expenses, such as loss of wages and future medical costs. Only pain and suffering awards would be reasonably capped. Too often juries are swayed by the emotional arguments of glib plaintiff attorneys into handing down multi-million-dollar noneconomic awards. In this new era of health care reform, everyone must take responsibility to propose rational solutions to the problems plaguing the system. Caps are such a solution.

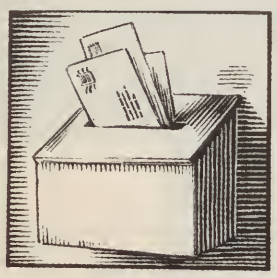
During the most recent legislative session in Springfield, Illinois physicians prompted introduction of a bill capping noneconomic damages in civil cases at $250,000. While the measure successfully cleared the Senate, it was killed in the House Judiciary I Committee. We can take heart in our partial victory this year, but there is still a tremendous amount of work to do. Given the stranglehold the plaintiff bar has on the Democrat-controlled Illinois House, winning the struggle for caps in Springfield will not be easy. But I know my physician colleagues throughout the state are up to the task.

Doctors throughout the United States are committed to making health care reform work. And we're willing to make our share of compromises along the way. But to ignore caps as an integral component of health care reform defeats the intent of any reform initiative. Caps are working in California, and they can work here, too. So, let's encourage the General Assembly to take the flexibility the president is giving the states and enact caps. Then we really will see meaningful tort reform.



LETTERS

PAs promote health care teams



I read with great interest the "President's Letter" in the July 30, 1993, *Illinois Medicine*. I am encouraged that a physician who represents such an eminent organization is promoting the team concept in health care for Illinois.

As you may know, we started our Physician Assistant Program last year with eight students who are now performing their clinical clerkships. Our first-year class has grown to 22 students, and next year we plan to start offering a PA master's degree program to about 25 to 30 students per year. We are a primary care-oriented program, and our goal is to assist physicians in rural and underserved areas of Illinois. Therefore, we are eager to support your vision of health care delivery in this state, and while I do not completely agree with your description of PAs' duties (PAs do assist physicians in diagnosing and treating complex medical conditions), I do concur that health care will be far better served by all health care professionals working together as a team with coaches, captains, and so on. PAs, unlike some nurse advocates, do not want to work independent of a physician.

I would be happy to discuss PA education and utilization with you. Also, I would be delighted to provide you with more information about our students, our program or possible mechanisms to help Illinois State Medical Society members learn more about PAs. I am always eager to speak or write about the role of physician assistants on the Illinois health care team, so if I can be of any help to you in disseminating information about your vision of Illinois health care, please do not hesitate to contact me. Again, thank you for your understanding and wisdom, and I look forward to reading more of your president's letters.

– Michael P. Pagano, PhD, PA-C
University of Health Sciences/The Chicago Medical School
School of Related Health Sciences

Quarterly premium payments due

Don't jeopardize your malpractice insurance coverage. The Exchange is sending all policyholders reminder notices that quarterly premium payments are due Oct. 1. If your payment is not received by then, you will receive a cancellation warning. If your payment is not received by Oct. 15, your policy will be cancelled on that date, and all certificate holders on record, such as your hospital, will be notified. To reinstate your policy after Oct. 15, ISMIE must receive and process your premium installment by Oct. 26. Policyholders who have any questions or concerns may contact the Exchange underwriting division at (312) 782-2749 or (800) 782-ISMS. Please allow seven working days for mailing and processing your premium payment. ■

GUEST EDITORIAL

Health care plan doesn't have room for sacrifice

By Stephen Chapman

The best illustration of what's wrong with American attitudes about health care is that TV ad for an insurance company in which some guys are sitting in an office, looking like they just returned from a funeral. Turns out a co-worker broke his ankle in a company softball game. Won't our insurance pay his medical bills? someone asks. Not deductibles or co-payments, comes the grim reply.

Oh, the horror! This poor wretch, a prosperous-looking fellow with a steady job, could be out two- or three-hundred bucks. How will he feed his family? How will he pay his cable bill?

The ad exploits the widespread feeling that we are entitled to unlimited health care for nothing, a sentiment Bill Clinton does not plan to challenge. He came into office pledging to ensure universal access to medical care and to control costs. From the details released so far about his health care program, he will do the first of those two.

> *The melancholy truth, though, is that whatever reduces our individual costs will only increase our collective burden.*

One portent is the administration's haste to drop one good idea it raised – limiting the deductibility of employer-paid health insurance premiums. Currently, companies may write off all premiums and employees need not report them as income, making health benefits tax-free.

This is an incentive for workers to take their pay in insurance rather than wages, since the government taxes wages. It's also an incentive for employees to demand, and employers to provide, the most expensive policies – such as the United Auto Workers' "first-dollar" coverage, which spares members even deductibles and co-payments.

Thanks to lavish policies subsidized by the tax code, Americans get nearly five times as much medical care as they pay for out of their own pockets. The result has been rising demand, which has pushed medical expenditures through the roof.

Clinton has obviously resolved not to be accused of stinginess. His plan reportedly would guarantee coverage to everyone for just about everything: hospitalization, emergency room visits, physician services, preventive measures like inoculations and mammograms, eye care, dental care for kids, prescriptions and some mental health services.

Nursing homes, more psychiatric services and adult dental care will be put off, but only till the year 2000. Fee-for-service plans would feature a low deductible ($200 per person or $400 per family) and a 20-percent co-payment. People choosing an HMO would pay only a $10 fee per doctor's visit. Facelifts and sex-change operations are among the few procedures not included.

Now, generous health coverage for all is a fine thing. But it presents a major obstacle to another fine thing: containing our soaring expenditures on health care, which are one big cause of the federal deficit. The president, in fact, has said that budgetary discipline is impossible without health care reform, and he's right.

But his plan does nothing to discourage spending. Just the opposite. If you provide the best and most expensive health insurance not only to everyone who is now insured but also to everyone who is now uninsured, you will fuel the demand for care without increasing the supply, which is a formula for medical hyperinflation.

The president's approach suits the public mood. When a Harris poll asked Americans what they want health care reform to accomplish, 58 percent said controlling or reducing costs. What they obviously have in mind is not the nation's costs but their own. The melancholy truth, though, is that whatever reduces our individual costs will only increase our collective burden.

So how can we expand access without spending more? By restoring the original purpose of insurance – protection against ruinous expenses, not routine ones. (The only alternative is draconian government rationing, which in some places merely curtails care without cutting costs.)

People don't get insurance to cover normal auto maintenance and minor repairs. Why do they need insurance for the human equivalent? If Americans had to pay for ordinary medical bills themselves, they would be less apt to get treatment of marginal value – which in turn would help to reduce overall medical expenditures, health insurance premiums and taxes.

The worst defect in our health care system is that those without insurance can suddenly be buried in medical bills that they can never pay. That risk, however, can be removed by catastrophic coverage – an option that has gotten no attention in the current health care debate.

Clinton's plan goes well beyond protecting people against medical disaster. It does so in order to attract the mass of people who are entranced by the prospect of getting more and more for less and less. He hopes to buy the support of the voters with their own money, a trick Americans have seen before but have not yet learned to avoid.

Stephen Chapman's columns appear regularly in the Chicago Tribune. *This article, which appeared in the* Tribune *on Sept. 12, 1993, is reprinted with permission.*

ISMIE Update

President's Letter Focuses on Caps
PAGE 4

Exchange Quarterly Premiums Due
PAGE 5

Are risk retention groups too risky?

Insurance experts have recently learned valuable lessons about one of the newest competitors in the insurance arena. By Gina Kimmey

An insurance provision created by Congress in 1986 to make liability coverage more affordable and accessible generated a growing market for a class of insurers known as risk retention groups. The Federal Risk Retention Act of 1986 devised a means by which insurance buyers could more readily purchase liability insurance coverage, and has effectively created a loophole for some insurers.

The primary appeal of risk retention groups for physicians is their ability to offer lower premiums than do conventional medical malpractice insurers, said a spokesperson for the Illinois Department of Insurance. But since risk retention groups are not subject to state insurance regulations, they provide fewer safeguards than do their regulated counterparts. An irresponsibly run risk retention group could be a dangerous business decision, according to IDOI. Since the Act was passed, six risk retention groups, including Louisiana's Physicians National, have faced insolvency. These failures illustrate the drawbacks of insuring with such a group.

According to the 1993 *Risk Retention Group Directory & Guide*, the Act stipulates that a risk retention group may form as a liability insurance company under the laws of only one state. Conventional insurance companies, however, must be licensed in every state in which they do business. The owners of a risk retention group must also be its insureds, and membership is restricted to individuals engaged in businesses or activities related to their liability exposure, the guide states. Before a risk retention group is established, the prospective owners must complete a feasibility study or plan of operation that includes the coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer. The Act also mandates that the feasibility study be filed in the state in which the group is licensed, as well as in every state in which it operates.

Malpractice suits most often won by plaintiffs

Suits charging wrongful death or brain damage from malpractice are the most likely to be won by plaintiffs. Following are the median awards over the past five years:

Brain damage		Wrongful death	
1987	$2.65 mil.	1987	$500,000
1988	2.1 mil.	1988	454,500
1989	1.6 mil.	1989	650,000
1990	2.08 mil.	1990	550,000
1991	2.0 mil.	1991	555,000

Source: Jury Verdict Research

Physicians National was one of the first risk retention companies formed. According to news reports, then Louisiana Insurance Commissioner Sherman Bernard licensed Physicians National in 1987, after five other states denied its licensing request. Between 1987 and 1991, Physicians National collected $120 million in premiums from 5,000 physicians in 47 states.

Physicians National said it would cut the costs of medical malpractice insurance by insuring only "good" physicians. But, according to a $20 million lawsuit filed by Louisiana Insurance Commissioner Jim Brown,

MALPRACTICE ROUNDUP

ERs need policies for phone orders

Hospital medical staffs and legal counsel for institutions that permit private physicians to telephone drug orders to their emergency departments should develop policies that protect patients from injury and doctors from liability, according to *Loss Minimizer*.

Such policies should state that only physicians who have hospital staff privileges may phone drug orders to the ER. Policies should also specify the types of medication orders that may be phoned. In addition, they should list the minimum documentation requirements needed for phone orders, including the patient's vital signs; a nurse's triage assessment; the date and time the physician last examined the patient; the medication name, amount, route and site of administration; the patient's response to the medication; and the patient's condition at discharge. The patient should receive written follow-up instructions, and a copy should be sent to the prescribing physician.

To avoid possible misdiagnoses or inappropriate medication administration, hospital policies should require patients to be examined by a physician in the ER before telephone orders are carried out. ■

Immunity granted in organ donation case

The Superior Court of Pennsylvania upheld a lower court decision that said a hospital acted appropriately when it made an unidentified deceased patient's organs available for donation. As reported in *Hospital Risk Management*, within an hour of his arrival at the emergency room, the patient, who had been shot in the head, was declared brain-dead by a staff neurosurgeon. After police were unable to locate any family members, the hospital obtained a court order to remove the patient's organs for use by the area transplant program.

Several hours after the patient's heart and kidneys had been removed, police located the patient's sister. The patient's family subsequently sued the transplant program and its coordinator; the hospital, its president and administrator; the neurosurgeon; and the surgeon who removed the organs for transplant. The defendants were charged with mutilation of a corpse, intentional infliction of emotional distress, civil conspiracy, and assault and battery.

The lower court granted the defendants a summary judgment based on qualified immunity provisions in Pennsylvania's Anatomical Gift Act. The Act designates a list of persons who, at the time of death, have the authority to make organ donation decisions. Since no family members could be located, the hospital acted as "any other person authorized or under obligation to dispose of the body" and made the organ donation decision. The court ruled that the Act does not require a waiting period before a decision regarding organ donation is made, nor does it hold the hospital responsible for searching for relatives before making a decision. The appeals court affirmed the ruling, contending that the hospital had acted in good faith and had the authority to make the decision it did, within the specifications of the statute. ■

Second-generation implant suits

Medical Liability Monitor reported that the latest breast implant lawsuits are being filed by mothers who claim that the silicone in the devices may have harmed their children. More than a dozen such lawsuits have been filed.

Plaintiffs have alleged that silicone has been found in mothers' breast milk, crossed through the umbilical cord or placenta, or led to autoimmune disease, which complicates pregnancies. They also have claimed their children developed problems including learning difficulties, dermatological disorders and injuries to their immune systems and internal organs. Former silicone-gel breast implant manufacturers are conducting studies to determine whether such links can be verified. ■

Physicians National charged premiums 50 percent to 60 percent lower than the price needed to maintain the company's solvency. In addition, the company charged very low rates to insure physicians with malpractice problems, drug and alcohol problems, and questionable training. The company was liquidated in November 1991. But because the Act specifically exempts risk retention groups from participating in state guarantee funds, all Physicians National insured physicians and claimants have no protection through such a fund. Conventional insurers are required to participate in the funds.

"One of the most important factors of an RRG is the state in which it is regulated," said Karen Cutts, managing editor of *The Risk Retention Reporter*, a monthly journal for the risk retention marketplace that monitors activity of risk retention and purchasing groups. "Because the RRG Act contains a single-state regulatory provision, if that state doesn't have strong, effective regulation, I think that is something that definitely should be considered." In Louisiana, for example, 65 insurance companies failed during Bernard's tenure with the state insurance department.

Some hospitals and clinics won't accept a risk retention group as a credible physician liability insurer.

THE GREATEST GROWTH in risk retention groups has been in medical malpractice insurance, Cutts said. In today's marketplace, it is especially important for physicians to research the kind of company they select for their liability coverage, because there are more companies to choose from than there were just a few years ago, the IDOI spokesperson said. Liability insurance experts say the key to a successful risk retention group is solid financing, a narrow focus and slow growth.

Physicians should also look carefully at company management, the IDOI spokesperson said. To be licensed in Illinois, risk retention groups must have $1 million in capital and $1 million in surplus. However, licensing rules in Illinois are stricter than in most other states, the department said. Risk retention groups can sell liability insurance in Illinois without being licensed here or showing any intent to remain active long-term in Illinois. Currently, only one risk retention group licensed in Illinois is providing medical malpractice insurance, but six or seven are selling medical malpractice insurance here, IDOI said.

Physicians considering purchasing their liability insurance through a risk retention group should prepare to make a long-term commitment, said Cutts. Many risk retention groups require a physician's premium plus a capital investment, which may not be refundable if the physician leaves the group. "An RRG requires a long-term commitment, which means members must be willing to stick with the group even when the market is soft, as it is now," said Cutts. "Members of successful RRGs aren't there just to reduce their rates, but for the risk management and loss prevention programs, and because they want more involvement with the company than they have experienced with a conventional insurer."

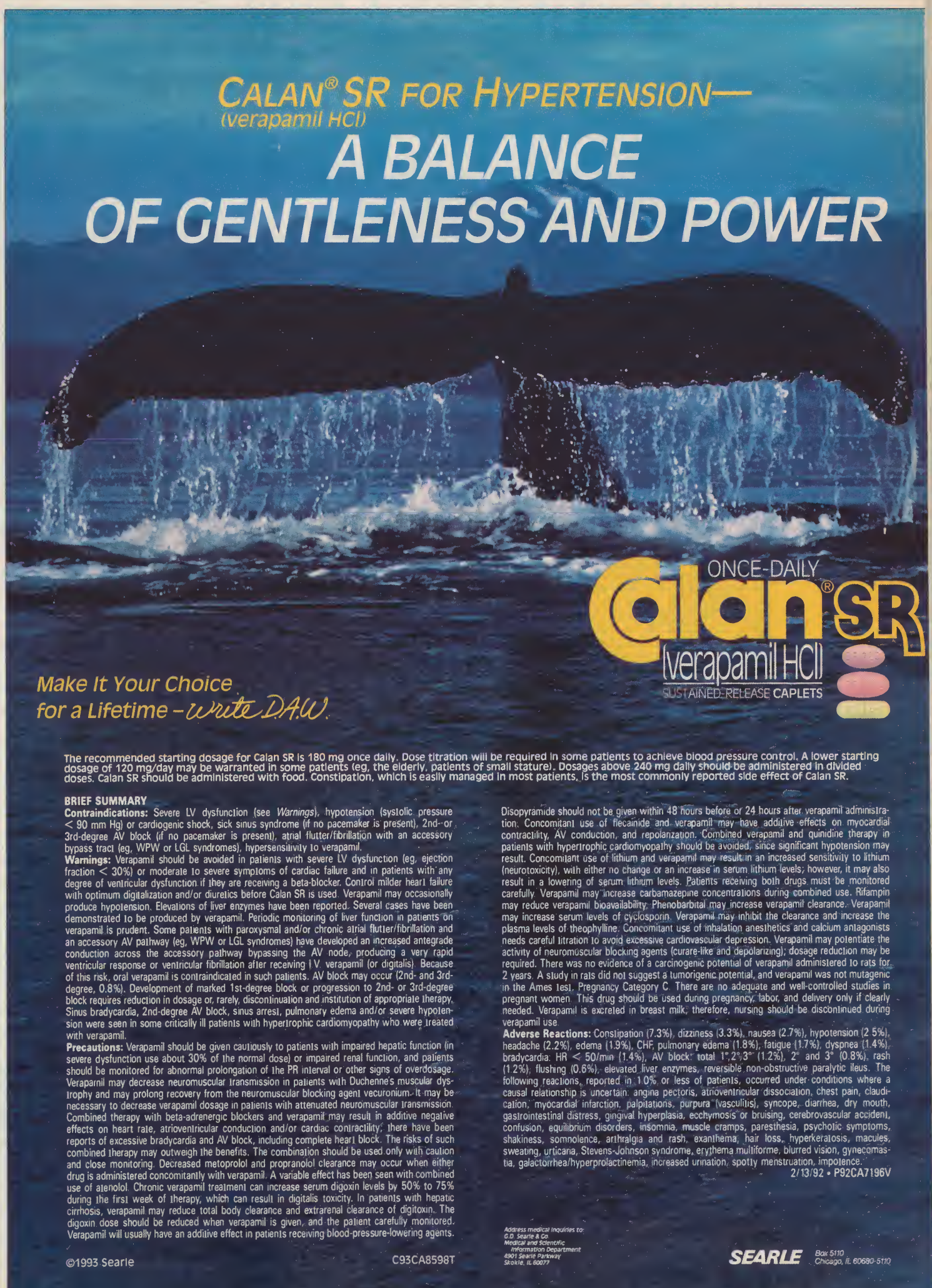
In almost every state, medical professional liability insurance is available from physician-owned insurance carriers, said Harold L. Jensen, MD, chairman of the ISMIE board of governors. "While ISMIE is a conventional insurance company in its regulatory capacity, it is physician owned and managed, and not at all conventional in its goals of providing the best liability coverage at the fairest rates. The company also places a strong emphasis on risk management and physician involvement.

"When selecting a malpractice insurance carrier, physicians should be sure to seek out a company – whether it's a conventional insurer, a risk retention group or otherwise – that has a strong track record of being there to support its policyholders when they need it," Dr. Jensen continued. "The Exchange has been offering insurance to ISMS members since 1976. We are committed to being there for Illinois physicians."

PHYSICIANS SHOULD ALSO BE WARY of a risk retention group's ability to assess additional premiums through surcharges to help build the company's surplus, IDOI warned. In addition, some hospitals and clinics won't accept a risk retention group as a credible physician liability insurer, said the IDOI spokesperson.

Low premiums should not be the only criterion for choosing a risk retention group as a malpractice insurance carrier, experts caution. In fact, Cutts said, most failed risk retention groups tried to attract insureds by lowering their premiums to the point that they could not cover their losses. This is dangerous to physicians and patients.

To determine if a particular risk retention group is licensed in Illinois, physicians may call the Department of Insurance at (217) 782-1757 or (217) 782-4701. ■




John McNulty

Albin

Receptionist's speed, grace earn honors

Described by her nominator as a receptionist who is always "pleasant and helpful," Susan Albin won the ISMS Employee of the Month award for September. Albin was hired as a receptionist for ISMS, the Exchange and the Illinois State Medical Insurance Services in September 1985. Since then, she has assumed supervisory duties, and this year she began overseeing furniture purchasing for ISMS.

"I don't think anyone comes close to Susan in maximizing results on the switchboard and in the reception area," said Diana Role, ISMS vice president of management services, in presenting Albin her plaque and check for $200.

"[Albin's] service is prompt, efficient, helpful and pleasant," her nominator wrote. "She never lets the frustration of her job interfere. Susan is the best receptionist I have ever encountered."

"To be recognized this way is especially appreciated," Albin said. "It's definitely a great honor. I just want to say a sincere thank-you."

All permanent, full-time ISMS employees, with the exception of senior management, are eligible for the Employee of the Month award. To nominate a staff member, contact the ISMS human resources department at (312) 782-1654 or (800) 782-ISMS. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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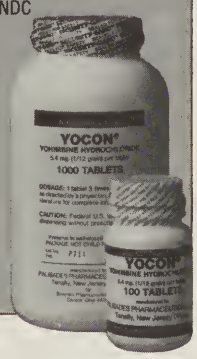
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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ENDING VIOLENCE

Chicago physicians aim to stop the killing



John McNulty

By creating new anti-violence programs, doctors hope education and counseling will make a difference.

BY ANNA BROWN

Physicians know that victims of violence often become patients. But physicians may not know they can help keep these patients from returning to emergency rooms with gunshot, knife or fist wounds, said John P. May, MD, a primary care internist at Cermak Health Services of Cook County Jail.

Dr. May is the author of a recent study, published in the July issue of the *Journal of General Internal Medicine*, showing that patients at greatest risk for committing or becoming victims of violence are receptive to homicide-prevention counseling. Dr. May focused his study solely on African-American males in the United States because homicide is the No. 1 cause of death among males between the ages of 15 and 34 in this group, he said.

Dr. May stressed, however, that violence is not just an African-American problem. "Violence affects all communities. We're immersing ourselves in a gun culture, which can only lead to despair and hopelessness."

In the study, Dr. May assessed patient responsiveness to physician counseling about firearms and homicide. The patients were interviewed at a walk-in clinic during treatment for problems unrelated to violence. They were offered counseling about six preventive medicine topics, including firearm safety. According to the study, post-visit interviews revealed that participants recalled the discussion of firearms more than any other issue.

"Physicians need to be concerned with all risk factors," he said, noting that 25 percent to 35 percent of his patients have been shot. "Violence is looked at matter-of-factly [by] them. Some hold up a bullet wound as a badge of courage. People act casually about it, but they're in denial. There's a real fear that becomes repressed without counseling." Such repression can lead to further violence, he added.

Some risk factors for injuries stemming from violence include using or selling drugs, owning a weapon and fighting frequently, according to Dr. May. He said physicians, especially those in primary care, can play larger roles in violence prevention by recognizing risk factors and discussing the subject with their patients. They can help patients open up and talk about personal experiences, and counsel them about preventing

(Continued on page 10)

Ending violence

(Continued from page 9)

future injury. "Don't judge, but let them know you recognize the risk and that you're expressing concern for their well-being," he said. "Discussion is the start of the process. It needs to be reinforced with every visit."

In addition to conducting the study, Dr. May founded Rise High Projects, a group that has developed anti-violence posters and distributes them throughout the country. Recently, the group received a $10,000 Joyce Foundation grant to place the posters, which feature slogans such as "Real Men Don't Play with Guns," on Chicago rapid transit trains and buses.

Dr. May founded the group and started the poster project last year with the help of several friends. The project was prompted when he visited a West Side high school and saw posters encouraging students to watch their cholesterol and exercise. "These are important messages but not the most appropriate," he said.

Dr. May said that although the posters may not directly save lives, they are valuable because they heighten awareness about violence.

The Chicago Medical Society has also stepped up its violence-prevention efforts. CMS President Sandra F. Olson, MD, has appointed a committee to address violence in Chicago. The committee's chairman will be M. Leroy Sprang, MD, an Evanston Ob/Gyn.

ANOTHER GROUP, the Chicago Area Anti-violence Project, was formed last year by Dr. May along with several other physicians and health care professionals. It is sponsored by the Chicago Department of Health and the Cook County Bureau of Health Services. The group's goal is to create a comprehensive violence-prevention program, Dr. May said.

Currently, the anti-violence project is developing several programs, including a data base to allow agencies to review the latest research in violence prevention at the state level and nationwide. Project members are also developing a list of violence prevention programs to be used as a resource for health care and social service workers. The group is producing a video for young children about the dangers of handguns. In addition, group members speak at special events, such as the Big Cities Health Conference held in Chicago this summer.

"Five years ago, people knew nothing about violence prevention," said Robert F. Smith, MD, chairman of the project and medical director for the CDOH trauma injury control program. "Now they're much more sophisticated. They want to know what works. We're focusing on the specifics by breaking an overwhelmingly large problem into component parts.

"It's important that physicians educate themselves about violence as a medical problem," he continued. "Then they can educate the public. It's necessary and appropriate to reach out to the community to make violence less likely." ■

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Auxiliary kicks off anti-violence initiative

This fall, the ISMS Auxiliary is introducing a program to help physicians detect signs of domestic violence in their patients and treat victims. Auxiliary President Mindy Chadwick will kick off the anti-violence program with a presentation during the Auxiliary's Women's Health Seminar Oct. 6 in Springfield.

"Not all physicians are taught about domestic violence in medical school," Chadwick said. "Since it is a prevalent problem, we hope we can provide them with the information they need to begin detecting signs of violence and helping patients who are victims."

The joint Auxiliary-ISMS project will soon be presented at county medical society meetings throughout the state, Chadwick said. The program includes a three-minute video produced by the AMA and a discussion period. Auxiliary members will discuss ways that physician participants can get more involved in domestic violence-prevention activities, such as enrolling in the AMA's National Coalition of Physicians Against Family Violence, building community coalitions, sponsoring seminars and establishing violence-prevention committees. The Auxiliary will also distribute resource materials to physicians, including lists of shelters; county, state and national agencies and departments dealing with abuse; and AMA and ISMS resources.

Chadwick said she hopes the program will eventually expand to include public education and more physicians will become advocates for victims of family violence.

"All victims of family violence need to know they can trust a physician, that the healing process can start there," Chadwick said. "Victims need to know someone believes them and that there is help available." ■

– Anna Brown

Flu shots

(Continued from page 1)

tiveness of supplying free flu vaccines to seniors were generally favorable – and somewhat ambiguous, Dr. Strikas explained. Measures of effectiveness and savings were influenced by outside factors, such as severity of the flu season and a general rise in vaccination rates before and during the study.

"Nationally, flu vaccination rates went up [during the study], but the intervention sites had more striking increases," Dr. Strikas said. "It's very hard to measure flu vaccine effectiveness. It's harder to measure in a mild season because there is less pneumonia present."

ILLINOIS PARTICIPATED during the last two years of the $69 million study. The CDC and the U.S. Health Care Financing Administration provided vaccine to 644 private and public providers in 34 Illinois counties, according to the Illinois Department of Public Health. During the second year that Illinois participated – the last year of the study – about 95,000 seniors received free flu shots.

According to the study results published in the Aug. 13 issue of CDC's *Morbidity and Mortality Weekly Report*, pneumonia and influenza are the sixth leading cause of death among people age 65 and older in the United States. During the study, the number of doses of vaccine administered in intervention areas in the 10 participating states increased from 26 percent in 1988 to 51 percent in 1992.

"It's nice to have this political victory," Dr. Strikas said. "But the problem is that Medicare will not make it easy to get reimbursed." He said payments from Medicare for the shots will probably not exceed $8, and reimbursement might sometimes be less. The average patient cost for a single flu immunization, including administrative expenses, can range from $15 to more than $25. He said a small number of physicians is concerned that the government's paperwork requirements and low reimbursement rates might discourage some providers from offering the vaccine.

In most cases, Illinois physicians who give flu shots to elderly patients can bill Medicare for an office visit, the vaccine and administration of the vaccine. However, physicians should refer to the August issue of the *BCBSI Medicare B Bulletin* for billing specifics. For more information, doctors may contact Blue Cross and Blue Shield of Illinois, the state's Part B carrier, or the ISMS health care finance division at (312) 782-1654 or (800) 782-ISMS. ■

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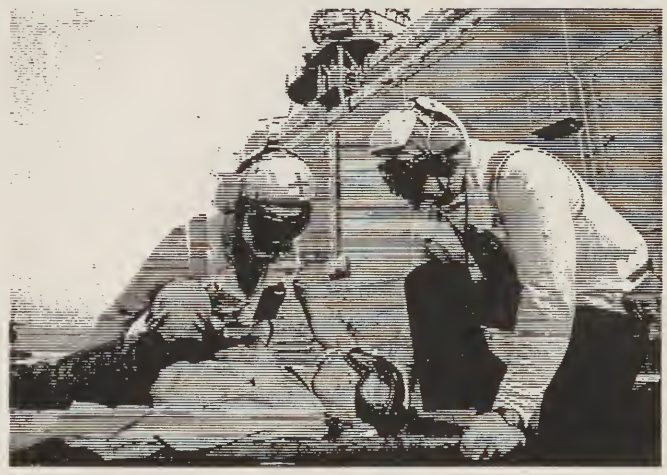
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Health bills

(Continued from page 1)

postsurgical recovery centers. ISMS supports such demonstration projects, provided the facilities obtain a certificate of need and implement appropriate peer review, credentialing and quality assurance mechanisms. Another bill dealing with postsurgical recovery centers was signed by Edgar. H.B. 1852, sponsored by Rep. Tom Ryder (R-Jerseyville) and Topinka, mandates 15-minute travel times between postsurgical recovery centers and general acute care hospitals with which the centers maintain emergency-backup relationships. The measure also requires development of regulations to accommodate transfers from hospitals to postsurgical recovery centers after certain procedures.

Edgar signed S.B. 180, amending the Child Passenger Protection Act, on July 1. Sponsored by Sen. John Cullerton (D-Chicago) and Rep. Barbara Flynn Currie (D-Chicago), the bill mandates that anyone transporting a child in Illinois – including nonresidents – comply with child restraint system requirements, by using seat belts and car seats. Illinois residents were already required by law to use these restraints.

The governor also signed ISMS-supported legislation amending the Medical Practice Act and the Code of Civil Procedure to regulate stays of disciplinary actions. S.B. 601 was crafted in response to a state Supreme Court ruling allowing dentists to continue treating patients until any pending disciplinary actions filed against them by the Illinois Department of Professional Regulation are resolved through the civil courts. The new law allows physicians to continue practicing only if a court stays the discipline because evidence shows the doctor is not a danger to the public. The bill was sponsored by Sen. Peter Fitzgerald (R-Palatine) and Rep. Bob Biggins (R-Elmhurst).

The governor also signed the portion of H.B. 1974 allowing visiting medical professors to demonstrate or perform certain techniques, in addition to studying them. The measure was sponsored by Rep. Edgar Lopez (D-Chicago) and Sen. J. Bradley Burzynski (R-Sycamore).

Fitzgerald sponsored recently signed ISMS-supported legislation affecting physician medical licenses. S.B. 602, cosponsored by Rep. Miguel Santiago (D-Chicago), amends the Illinois Controlled Substances Act. The bill requires IDPR to receive complete peer-reviewed input from the appropriate licensing or disciplinary board before taking action against individuals holding controlled substance licenses. S.B. 603, sponsored by Fitzgerald and Rep. Frank Giglio (D-Calumet City), establishes a $100 fee for individuals who apply for their medical license within the last 12 months of the three-year renewal cycle. Signed Aug. 6, the bill ensures that physicians will not have to pay the full fee if they are issued a license during the last year of a renewal cycle. The standard $300 fee remains intact for all other license renewals.

On Aug. 13, Edgar signed H.B. 671, sponsored by Rep. Mary Flowers (D-Chicago) and Sen. Earlean Collins (D-Chicago). The new law prohibits courts from mandating birth control – including implants and injections – for individuals who are convicted of a felony or misdemeanor. ■

Budget

(Continued from page 1)

decreased from 7,241 to 7,205. "Thirty-six beds is not much of a reduction," she said, comparing the reduction to fiscal 1993, when the department lost funding for 625 beds.

About half of the department's budget will be used to operate the state's 21 mental health facilities, Handy said. "This year we're hoping that as community providers take on more responsibility, we can reduce the census within facilities at a modest level."

According to Handy, Illinois' mental health facility staff-to-patient ratio is the worst in the country. "Our goal is to allow ratios to improve as the census goes down." To achieve this, the department plans to add 20 staff members to its facilities. The additional staff will make the ratio "much more stable and manageable," Handy said.

THE DEPARTMENT RECEIVED $2.5 million more than the governor had originally proposed, Handy said, explaining that the additional funding resulted from back-and-forth negotiations during the budget process. Edgar's proposed funding was reduced by $1.3 million in personal services and $400,000 in other operational lines, she said. The legislature also cut 50 percent from Edgar's $2.2 million request for mental health reform.

Under mental health reform programs, the state will identify individuals who have a serious chronic mental illness and who often return to state facilities. The department will then assign them to case managers to provide "whatever they need to function," Handy said. The program is critical to prevent these individuals from becoming homeless, she added. ■





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WHEN MEDICAL RECORDS ARE DESTROYED (PAGE 9)

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Physicians help patients cut out tobacco

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SUBSTANCE ABUSE

PAGE 5

Government expands self-referral restrictions

MEDICARE: OBRA '93 alters physician self-referral regulations. By Gina Kimmey

[SPRINGFIELD] Illinois physicians should be aware of changes in the Medicare laws governing physician ownership and self-referral, said ISMS analysts. The new rules, which are included in the Omnibus Budget Reconciliation Act of 1993, also modify Medicare and Medicaid anti-kickback provisions to remove some of the potentially "abusive" practices that had still been permitted under the previous law, according to an ISMS analysis.

Effective Jan. 1, 1995, OBRA '93 expands the prohibition on referrals for clinical laboratory services to include "designated health services." This extends self-referral and anti-kickback provisions to designated Medicare health care services, not just clinical laboratory services. These services include physical therapy, radiology and other diagnostic testing, durable medical equipment and outpatient prescription drugs.

The regulations prohibit a physician from billing Medi-

(Continued on page 23)

Illinois and Michigan assisted-suicide laws similar

ETHICS: Although ISMS-member physicians believe physician-assisted suicide is wrong, Michigan physicians want more debate. By Anna Brown

[SPRINGFIELD] The objective of Illinois' new assisted-suicide law, signed by Gov. Jim Edgar on Aug. 20, parallels that of ISMS policy stating that physicians should not help patients end their lives. The legislation imposes stiff penalties on anyone who helps an individual commit suicide.

H.B. 819 added language to the Criminal Code of 1961, making assisted suicide in Illinois a Class 4 felony. The measure defines assisted suicide as providing the means for another person to take his or her own

(Continued on page 21)

INSIDE

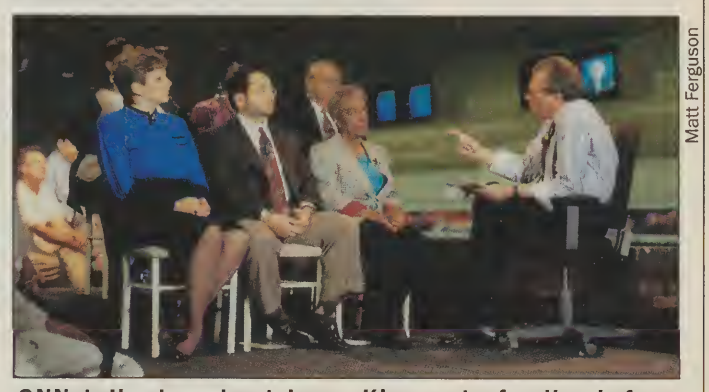
Medicare cracks down on overbilling
PAGE 3

End of summer marked by pertussis outbreak
PAGE 4

Public health center receives private help
PAGE 17

DEPARTMENTS

News Briefs.....2
Commentary.....6
ISMIE Update.....9
Classifieds 19



Matt Ferguson

CNN talk show host Larry King gets feedback from Chicagoans about President Clinton's health care reform proposal. King's live nightly call-in show originated from a Chicago bowling alley Sept. 22 following Clinton's nationwide address in which he outlined his plan.

Evanston Hospital votes to join Northwestern network

AFFILIATION: Some physicians fear Evanston Hospital will lose autonomy. By Anna Brown

[EVANSTON] Evanston Hospital medical staff members made their voices heard Sept. 10 when the Evanston Hospital Corp. board voted 39-2 to conditionally join the Northwestern Healthcare Network. The other network partners are Northwestern Memorial Hospital, Children's Memorial Hospital and Highland Park Hospital. Evanston Hospital Corp., which includes Glenbrook Hospital, was the last of the four affiliation partners to vote on formalizing the affiliation.

After weeks of intensive lobbying by physicians, the board agreed to join the network only if the hospital is allowed flexibility. Physician staff members had expressed concern that by joining the network the hospital could lose autonomy and diminish health care services for the North Shore community, according to M. LeRoy Sprang, MD, chief of Evanston's medical staff.

Evanston Hospital has the most to lose by joining the net-



Dr. Sprang

work, Dr. Sprang said. Children's Memorial and Highland Park hospitals do not compete directly with Northwestern Memorial, as Evanston Hospital does. Many physicians fear that the network authority could decide to relocate some of the hospital's medical services that are important to the Evanston community. "The community has supported the hospital for years," Dr. Sprang said. "We want to make sure our patients receive the same high level of care."

Dr. Sprang said negotiations between the medical staff and the board led to an equitable resolution that enabled physicians to support the hospital's continuation in the Northwestern network. The four founding partners were required to declare their intention to stay in the network by Oct. 30, said David Loveland, Evanston

(Continued on page 22)

Clinton announces health care plan



President Clinton's long-awaited health care reform proposal, as currently written, promises universal access to all citizens. In addition, an ISMS analysis of the plan outlines the following elements:

- All citizens will be required to have health insurance. They will be able to choose among a higher-cost fee-for-service option, a lower-cost network plan and a combination plan, all of which will cover the comprehensive minimum benefits package.
- The system will be governed by the National Health Board, and states will be required to submit to the board a state plan meeting federal requirements. States may enact single-payer systems.
- Balance billing will be banned.
- Global budgets will be set to limit increases in health care costs.
- Quality management and accountability will be overseen by a 15-member council that will report to the National Health Board. No physicians or other providers will be named to the council.
- Standardized forms will be developed and implemented for use by all providers and health plans, including Medicaid and Medicare.

(Continued on page 21)

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MORE THAN 25,000 PEOPLE WALKED 10 kilometers (6.2 miles) along Chicago's lakefront Sept. 12 to raise money for AIDS prevention and care programs. Since 1990, AIDS Walk Chicago has raised more than $1.2 million. This year's fourth annual walk raised more than $900,000 in pledges. Proceeds benefit 13 Chicago agencies that provide food, information and health care to individuals with AIDS and HIV. For information about future walks, contact AIDS Walk Chicago at (312) 665-1700.



Carla Sommerfeld

IDPR appoints new medical coordinator

[CHICAGO] The Illinois Department of Professional Regulation has named David K. Deets, MD, as the department's chief medical coordinator. Dr. Deets is a Dixon general surgeon and a former state legislator. In his new position, his main responsibilities are enforcing the state's Medical Practice Act and maintaining an advisory role with the Medical Disciplinary Board and IDPR's medical investigations unit.

Dr. Deets' day-to-day duties include reviewing complaints lodged against Illinois physicians and rendering a medical opinion on particular cases. The medical coordinator works closely with the department's investigators and attorneys to determine whether cases have merit. As medical coordinator, Dr. Deets also monitors physicians to ensure their compliance with probation or other disciplines against their licenses.



Dr. Deets

Dr. Deets will also work closely with deputy medical coordinator Robert J. Schafer, MD, a Petersberg family physician. Dr. Schafer's responsibilities include reviewing mandatory reports submitted to the department, such as medical malpractice judgments and settlements.

In addition to his work with IDPR, Dr. Deets will continue practicing medicine in Dixon. He is a past president of the Lee County Board of Health and the Lee County Medical Society. Dr. Deets is a fellow of the American College of Surgeons and a diplomate of the National Board of Medical Examiners and the American Board of Surgery. He received his medical degree in 1972 from Loyola University's Stritch School of Medicine. ■

ADA wins Data Bank suit

[CHICAGO] In a decision that could affect health care providers nationwide, a U.S. appeals court ruled in favor of an American Dental Association claim that some reporting requirements for the National Practitioner Data Bank violate federal law.

According to the ADA, the Health Care Quality Improvement Act of 1986, which authorized creation of the Data Bank, stated that only "entities," such as insurance companies or peer review organizations, would be required to report certain actions. In its suit, the ADA argued that the U.S. Department of Health and Human Services had improperly interpreted the statute when it issued Data Bank reporting rules that required individual health care providers to report themselves, said Mary Logan, ADA legal counsel. The ADA also contended that the HHS regulation enlarged the class of payments that must be reported to include "noninsurance" payments such as fee refunds.

"We were outraged that [HHS] would make that interpretation," said Logan. She cited as an example a dentist who refunds payment for dentures to a dissatisfied patient. Under the HHS regulation, the dentist would have to report the refund to the Data Bank.

The U.S. Court of Appeals ruling concluded that the "HHS regulation requiring each 'person or entity' that makes malpractice payments to report to the National Practitioner Data Bank violates the clear language of the Health Care Act insofar as it requires individual practitioners to report." By stating that HHS is not authorized to force individual health care providers to report themselves, the court rendered the patient refund issue superfluous, Logan said.

"An individual should not have to report himself or herself to the Data Bank, and the court upheld that principle," said Logan. ■

State to lose funds without helmet law

[SPRINGFIELD] Since Illinois failed to enact a law mandating motorcyclists' use of helmets by the Oct. 1 deadline, the state will lose $5.3 million in federal road construction funds over two years, according to state officials. Although Sen. John Cullerton (D-Chicago) introduced a mandatory helmet bill during the spring legislative session, the ISMS-supported measure did not emerge from committee. Illinois is one of only a handful of states without such a law.

Without enacting a helmet law, the state stands to lose $781,000 in incentive grants in fiscal 1994 and $4.5 million, or 1.5 percent, of highway construction funds in fiscal 1995, said Ed Orlet, a Cullerton staff analyst for the Senate Transportation Committee. The construction funds must now be redirected into highway safety programs, he said. In addition, if no helmet law is passed by October 1995, 3 percent of Illinois' highway construction budget must be redirected into safety programs, resulting in an $8.9-million loss in construction funds for fiscal 1996, Orlet added.

"The bill failed to get even a vote in committee," Orlet said, explaining that the bill was never called. "In the past it's gotten a little farther. It's a very charged issue. The motorcycle lobby is amazingly motivated, but it is surprising that [the bill] doesn't have more support. The penalties are formidable, and so are the health risks."

Orlet said Cullerton will introduce helmet legislation again next year and will continue to do so until a bill passes. "It's hard to understand the opposition when you look at the evidence," Orlet said, noting that in 1988, there were 76 fatalities per 100,000 motorcycles compared to 18 fatalities per 100,000 automobiles. An Illinois mandatory helmet law for motorcyclists was enacted in 1968, but it was declared unconstitutional by the Illinois Supreme Court and was repealed in 1969, Orlet said. However, during the time the law was in effect, the Illinois Department of Transportation reported that the annual average number of motorcycle fatalities decreased by 28.3 percent. During the first 17 months after the law was repealed, the average number of fatalities per year increased by 48.7 percent.

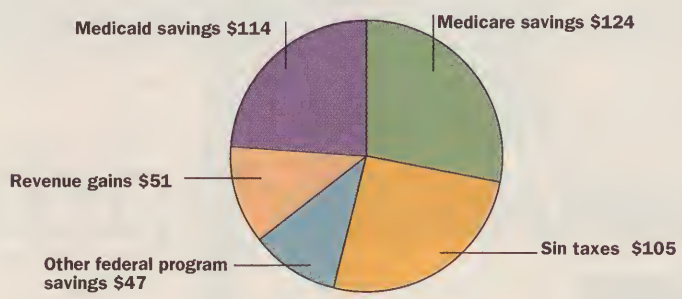
In 1986, when the state enacted a mandatory seatbelt law, the Supreme Court said it would no longer consider a mandatory motorcycle helmet law unconstitutional, Orlet said.

ISMS strongly supports legislative efforts to mandate the use of helmets by motorcycle riders in Illinois. The Society holds that physicians should encourage their patients who ride motorcycles to wear protective helmets and explain the effectiveness of helmets in preventing death or serious injury during collisions. ■

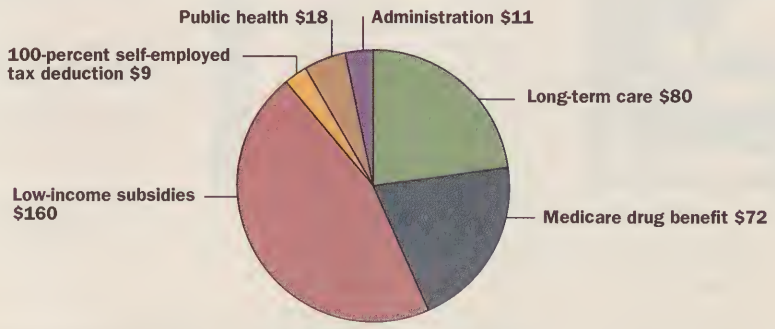
PHYSICIAN FACTS

Financing Clinton's health care plan

Source of funds — **Total $441 billion**
1994-2000 (in billions)



Use of funds — **Total $350 billion**
1994-2000 (in billions)



Source: The White House; Congressional Budget Office

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Medicare cracks down on overbilling

OVERCHARGE: HCFA warns physicians to comply with Medicare limiting charges or face serious consequences. By Gina Kimmey

[WASHINGTON] Nonparticipating physicians who consistently disregard Medicare limiting charges could face civil monetary penalties of $2,000 per overcharge and a five-year expulsion from the Medicare program, according to the U.S. Health Care Financing Administration. HCFA has instructed its Medicare Part B carriers to inform physicians about widespread noncompliance and the seriousness of potential sanctions, according to Blue Cross and Blue Shield of Illinois, the state's Medicare Part B carrier.

During the past year, carriers have increased monitoring by conducting biweekly reviews of physicians' limiting-charge compliance. If an overcharge by a physician is detected, the carrier sends a Limiting Charge Exception Report identifying the overcharge and providing information about bringing the fee schedule into compliance. The carrier also notifies patients about any overcharges, BCBSI said.

Although the number of LCERs issued is declining, many physicians do not acknowledge the overcharges or adjust their fee schedules, according to HCFA.

Physicians who receive one or two exception reports in a year can assume their billing clerk made a mistake, and they should ensure that these billing problems are corrected, said John F. Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. But if a physician is receiving LCERs every month or every two months, the "mistake" case is harder to justify, he said. If physicians receive an LCER, they should review it carefully and ensure that all staff members – including the doctor and billing clerks – fully understand the correct limiting charge, Dr. Schneider advised.

Nonparticipating physicians who do not accept Medicare assignment, but who see Medicare patients, must also abide by Medicare limiting charges, HCFA said. For 1993, these charges are 115 percent of the Medicare nonparticipating physician fee schedule.

Under federal law, physicians who repeatedly ignore the educational efforts of HCFA's Comprehensive Limiting Charge Compliance Program must be referred to the Office of the Inspector General, which may impose civil monetary sanctions. According to BCBSI, overcharges occur most frequently on billings for office visits, comprehensive office visits, injections, EKGs and X-rays.

Sometimes LCERs sent to physicians contain mistakes. Physicians should review LCERs to ensure that they reflect the proper procedures performed and billed. If physicians receive an LCER they believe is erroneous, they may submit a request for review to Medicare Part B, P.O. Box 4433, Marion, IL 62929; or request a telephone review by calling (618) 997-3190. For more information, physicians may also contact the ISMS health care finance division at (800) 782-ISMS or (312) 782-1654.

Dr. Schneider stressed that physicians should never disregard an LCER. "At $2,000 per overcharge, it's really not in your best interest to ignore those kind of mistakes. It's just not worth it." ■

Researcher studies nicotine addiction

[HOUSTON] Nicotine addiction causes about 10 times more deaths than all other types of drug abuse combined, said James Patrick, PhD, a neuroscientist at Baylor College of Medicine in Houston. Dr. Patrick is studying the molecular aspects of nicotine action in the brain to try to help people overcome nicotine addiction.

"People often seem to think drugs of abuse achieve their results through magic," he said. "But, in fact, they modify the body in some way that causes it to need that drug." For more than 20 years, Dr. Patrick has been studying how, where and why nicotine reacts in the brain.

According to Dr. Patrick, nicotine modification occurs through increases in some of the sites where nicotine chemically binds in the brain. His research indicates that smokers have about twice as many nicotine-binding sites as do nonsmokers.

"Telling people to 'just say no' after an addiction has developed is inappropriate and naive, because at that point it's a medical problem rather than simply a matter of choice." ■

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REPORT FOR *Illinois Physicians*

COMPREHENSIVE MEDICAL REVIEW BY MEDICARE PART B

Section 1842(a)(2)(B) of the Social Security Act requires Medicare carriers to apply *"safeguards against unnecessary utilization of services furnished by providers."* These safeguards include prepayment and post-payment claim reviews to identify inappropriate, medically unnecessary or excessive services. In the post-payment category is the Comprehensive Medical Review (CMR) which, as mandated by the Health Care Financing Administration (HCFA), will include approximately 70 Illinois providers in FY94 (October 1, 1993 through September 30, 1994).

The CMR process begins with review of reports that identify providers who have exceeded their peers (e.g., physicians in the same specialty and same locality) by two or more standard deviations in allowed billings for one or more services. It continues with review of reports that profile the practices of providers who have possibly over-utilized, with selection for audit those providers who appear aberrant in utilization.

In an audit, the medical records of 20 randomly selected patients who received the service(s) in question are requested from the provider, and reviewed for all services billed and allowed. The audit determines if the services were performed and were medically necessary. If records do not support the services, an educational letter is sent to the provider, usually requesting return of the overpayment for the service(s) in question. A provider may challenge CMR findings within six months of an audit, either informally by submitting information not previously provided, or formally by requesting a *"Fair Hearing."*

A provider who fails an audit is reviewed again within one year to determine whether or not the aberrant utilization has been corrected. If so, the provider's audit file is closed, and if not so, the file is referred to the carrier's Fraud and Abuse Unit.

(Issue: 10/08/93 - DB)

End of summer marked by pertussis outbreak

DISEASE: Public health officials work overtime to control whooping cough cases. By Gina Kimmey

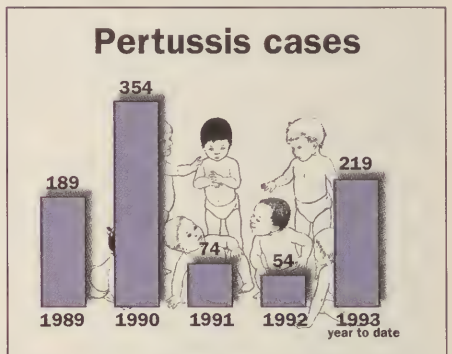
[CHICAGO] Illinois physicians should be on the lookout for patients with a persistent cough. It could indicate pertussis, warned Stan Shulman, MD, head of the division of infectious diseases at Chicago's Children's Memorial Hospital. "It is important to remember that even fully immunized children and adults are not generally immune to pertussis," Dr. Shulman said.

Reported pertussis cases are increasing across the state, but the outbreak is most severe in the Chicago area, public health officials said. During the first six months of 1993, only six cases of pertussis were reported in Chicago. But since late July, more than 146 cases have been reported in the metropolitan area, and another 73 cases have been identified downstate, according to the Illinois Department of Public Health. Only 54 cases were reported statewide during all of 1992.

"Whether this outbreak is controlled and eradicated in a matter of weeks, or whether it develops into an epidemic lasting months, is up to public health authorities, private medical providers and, ultimately, each and every one of us," said John Wilhelm, MD, Chicago Department of Health deputy commissioner for medical affairs. CDOH is currently working with the U.S. Centers for Disease Control and Prevention to monitor local outbreak-control measures, Dr. Wilhelm said.

In addition, CDOH officials have alerted the staff at its 15 clinics, as well as the department's public health nurses who make home visits, to watch for possible pertussis cases. The department has also contacted infection-control specialists at area hospitals and practitioners at HMOs and large private clinics. Officials said the key to controlling the current outbreak is education.

Pertussis is a highly communicable disease. Patients usually have symptoms similar to those of the common cold. As the disease progresses, coughing attacks develop that are characterized by a high-pitched "whoop" sound, CDOH said. Health officials warned that the disease can be fatal, especially in infants. The median age of cases reported in Chicago this year is about 6 months, and many of these young patients have required hospitalization, Dr. Shulman said. Most infants contracted the disease from a household contact such as a babysitter.



In vaccinated patients, the disease tends to be less severe, appearing as little more than a persistent cough, said Dr. Shulman. Pertussis is usually not diagnosed in these mild cases, because many physicians do not routinely test for the disease, he explained. But since adults serve as the primary carriers for pertussis, physicians should consider a pertussis diagnosis for any patient experiencing prolonged coughing or coughing that causes vomiting.

PERTUSSIS TREATMENT includes antibiotic therapy with erythromycin for 10 to 14 days, Dr. Shulman said. Although the medication does not greatly affect an established case of pertussis, treatment is important in limiting secondary spread, he added. If a case is strongly suspected or confirmed, all members of the patient's household and other close contacts, regardless of their immunization status, should be treated with antibiotics, according to Dr. Shulman.

Babies are typically born with some immunity to childhood diseases – such as measles, mumps and rubella – but infants have no inherited immunity to pertussis, said a CDOH spokesperson. Children should receive five pertussis vaccinations, which are part of the routine DTP immunization, at ages 2 months, 4 months, 6 months, 15 months, and before entering preschool or kindergarten. The level of immunity achieved through vaccination varies, the department said.

"Health care providers must identify and treat all cases promptly," Dr. Wilhelm said. "Individuals must take better care of themselves and seek medical attention as soon as there is a problem." ■

Breast of chicken



3-oz. cooked serving of chicken breast

Best of pork



3-oz. cooked serving of pork tenderloin

Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.[1,2*]

Compare pork with chicken[1,2*]

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz, cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.[1] According to new 1992 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.[1]

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1992. Agricultural handbook 8-10.
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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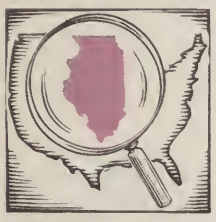
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Physicians, lawyers team up against substance abuse

EDUCATION: Joint program teaches students the dangers of drug and alcohol abuse. By Gina Kimmey

[ROCKFORD] Rockford-area physicians and lawyers have joined forces to fight a common enemy: substance abuse. They are participating in Partners in Prevention, a program aimed at warning schoolchildren about the health problems and possible legal ramifications of drinking alcohol and taking drugs. The program is sponsored by the Winnebago County Medical Society and the Winnebago County Bar Association.



Through Partners in Prevention, a physician and a lawyer speak at schools to try to "turn kids off of drugs before they get turned on," said June Taylor, WCMS' director of public and professional relations. Initiated by the AMA and the American Bar Association more than five years ago, the program was adopted in 1991 by WCMS, in cooperation with WCBA, after the national associations bowed out.

> *It's important for [kids] to hear this information from someone of authority instead of from their peers.*

"We had some meetings in 1990 to discuss the possibilities, and the first program was held in the 1991 school year," said Taylor. "We offered the program to all the sixth-, seventh- and eighth-grade teachers, and about two-thirds responded that they would be interested in participating. It was a win-win situation all the way around. We never heard a negative comment." Although the program was put on hold in 1992, Taylor said the medical society decided to reinstate the program this year, and more than 70 physicians and lawyers have already signed up to participate.

"It's important to educate the kids. It's important for them to hear this information from someone of authority instead of from their peers," said Ralph R. Velasquez, MD, a Rockford family physician and program participant. "It's really good to combine the health and legal effects. It's critical that they understand how drugs affect their bodies now and the potential long-term effects."

Although it is important to talk to children who are interested in learning more about substance abuse, Dr. Velasquez said that reaching teenagers who think they already know it all is even more satisfying. "It's interesting to see their responses and dispel some of the myths, such as that drugs are not addictive; that one drink won't hurt you; that it's OK, you won't go to jail. We show them that the so-called class experts aren't so expert after all."

The attorneys who participate also offer the children clear reasons to avoid drugs and alcohol, according to program participant Charles Prorok, a Winnebago County deputy state's attorney. "I have seen the problems that people get into, and I thought I could be of assistance in getting kids to forget about engaging in drugs or alcohol before they even start. I tell them it's not all as glamorous as the television and their friends make it out to be. They may see a 12-year-old friend selling drugs and making a lot of money, but what they don't realize is that kid isn't going to live to be 18."

Prorok said telling children that they could go to jail or forfeit career opportunities is a powerful message. "I explain that having something like this on their record could prevent them from ever having the chance to go to medical school or law school, or become a police officer. They usually don't look that far into the future.

"They need to understand the difference between being 17 and being 18 [regarding] how the judicial system will treat them," Prorok continued. "At 17, the courts will try to rehabilitate you. But at 18 there are no more kids' games; they just lock you up in a real jail."

The students' responses have been "wonderful and reassuring," said Dr. Velasquez. "It's important for them to know that there is someone they can talk to other than their peers, who will listen to them and give them the right answers." ■



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EDITORIAL

A work in progress

The time for a national health care reform debate is long overdue, and ISMS welcomes its kickoff. In some respects, we're off to a good start. At the ISMS Annual Meeting in April, the House of Delegates approved policy on health care reform, and the Clinton plan contains some of those concepts. For example, the Society supports universal access through an employer-funded insurance mandate, with subsidies to help small businesses provide coverage for their employees.

In addition, ISMS policy agrees with the plan's emphasis on preventive care. By encouraging patients to obtain such care before serious symptoms occur, we will help contain medical costs.

To make health insurance portable and affordable for Illinoisans, ISMS also supports certain insurance industry reforms. Specifically, we advocate eliminating pre-existing condition limitations in policies and community rating to spread risk more equitably among insureds.

Finally, ISMS policy concurs with state flexibility in implementing reform. States should be able to customize the system to best meet the needs of their residents.

Although there is common ground between ISMS policy and the Clinton plan, we believe some elements of the proposal must be changed. ISMS does not support expanded bureaucracy that intrudes into the doctor-patient relationship. With extensive utilization review and peer review, and government-established caps on insurance premiums and annual budget targets, the federal government would likely be the central policy-maker in the new system.

The federal government must offer either realistic funding for a reformed system or realistic plans for rationing care. So far, ISMS has seen neither in detail. What will happen to Medicare and Medicaid patients faced with $238 billion in program cuts?

On most counts, medical malpractice reforms in the president's plan are inferior to those in Illinois. Our state needs a cap on noneconomic damage awards; without it, awards will continue rising. Capping these awards is critical to preserving access to care and to stabilizing out-of-control litigation.

The president's antitrust reforms are a good start, but much more protection is needed for physicians who must fairly negotiate service agreements with other health care providers. This protection would also enable organized medicine to better police its own ranks without fear of lawsuits.

When health care networks focus too much on dollars, patient care suffers unless physicians have the right to battle decisions based only on cost.

ISMS looks forward to working with legislators during the process of developing a plan that works for patients, and ensures access and quality health care for all Americans.

PRESIDENT'S LETTER

Responding to the Clinton proposal

By Arthur R. Traugott, MD



Our concern is that all our patients receive access to health care without compromising the quality of that care.

The debate recently launched by President Clinton offers a great opportunity to bring needed reform to the nation's health care system. The president's proposal includes some ideas that ISMS endorsed at its 1993 Annual Meeting. However, to truly provide the kind of system all Americans deserve, the president's plan requires significant changes.

I hope some of those changes will be a result of physicians' suggestions. Physicians are anxious to work with the White House and the Illinois congressional delegation to craft the best possible system.

Among the ideas we can readily embrace is universal access to health care through employer-provided insurance. The ISMS House of Delegates approved this approach at the 1993 Annual Meeting. No American citizen should be denied access to necessary medical care.

ISMS policy also supports insurance reforms, such as eliminating coverage limitations for pre-existing conditions, discontinuing the use of health status as a basis for premiums and providing "portable" health insurance so that people won't lose coverage if they change jobs or move.

However, if Illinois patients are to benefit from a health care system that truly serves their needs, some serious problems in the Clinton proposal must be addressed. Specifically, ISMS is concerned about Clinton's proposal for unprecedented intrusion of a centralized government authority into our economy and our everyday lives. As we understand the Clinton plan, doctor-patient decisions will be strongly influenced by federal government dictates rather than the needs of our patients.

ISMS strongly believes that patients should be allowed to make their own informed decisions about the type of health care they want for themselves and their families. Patients' freedom to choose a physician is essential to preserving the doctor-patient relationship. The managed care systems outlined in the Clinton plan will likely limit patients' choices in selecting a health plan, primary care physicians and specialist care.

Physicians and patients together must be able to make treatment decisions that are in patients' best interests. However, if the new system is inadequately funded or includes overall caps on health care spending, health care networks will focus too much on the bottom line and dictate decisions on the basis of cost.

Inadequate funding could reduce or eliminate capital that is needed for investment in innovative and advanced technologies in health care delivery. And, by necessity, rationing of health care would increase. Many Americans may find that they will be paying more money for less coverage.

It is truly disappointing that the president did not go further in proposing the legal reforms that are necessary to ensure that health care is available and that costs are held to a minimum. Changes proposed by the administration include limits on attorney fees, but Illinois already has stronger limits in place. Illinoisans would be much better served by establishing caps on awards for noneconomic damages in malpractice cases. Current liability laws have driven up medical costs as doctors feel pressured to practice defensive medicine. The fact is that some of the best and brightest physicians are the ones who are sued most frequently.

Antitrust reforms are also needed to loosen the restrictions on physicians' ability to negotiate service agreements with hospitals, insurers, managed care systems and other physicians, so that on behalf of quality care for patients, doctors can compete on an equal basis with other health care providers.

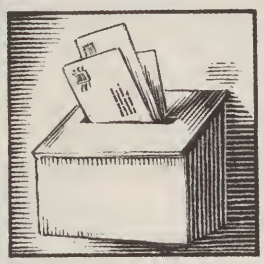
The Clinton proposal will dramatically change the way health care is provided for millions of Americans. Our concern is that all our patients receive access to health care without compromising the quality of that care.



"Yes. I'd say there have been side effects with the medicine. I had to get a second job to pay for it."

LETTERS

Call for medical savings accounts



My compliments on your list of questions in "Assessing Health Care Reform" ("President's Letter," Sept. 24 issue). I agree with your comments regarding the need for professional liability reform to reduce the costs of practicing defensive medicine. I also agree with the need to reduce administrative paperwork costs, which go up steadily as OSHA and other regulations expand, and the need to improve the practice of medicine by putting controls back in our hands.

However, you did not mention the advantage of tax credits for medical savings accounts. This option would restore the market mechanism for most small, usual expenses and would allow individuals to purchase insurance against catastrophic illnesses. The idea is receiving increasing attention in Washington, as well as among physicians. Enhancing the current U.S. system with concepts like this is so much better than enacting a new system similar to the one in Canada. That system is running into financial problems and is rationing care and impairing physicians' practice options.

I must also compliment you on the guest editorials in the Sept. 24 issue regarding malpractice reform and handgun violence. Both of these are excellent.

George E. Shambaugh, MD
Hinsdale

Illinois Medicine *welcomes letters on topics covered in the newspaper. Send letters to* Illinois Medicine, *20 N. Michigan Ave., Suite 700, Chicago, IL 60602. Letters will be edited for space and style.*

Time is running out to renew your license

Physicians who fail to renew their medical licenses in October will face serious consequences. The 90-day grace period approved by the General Assembly expires at the end of the month, and any physician who does not have a new three-year medical license at that time will be practicing medicine without a license. Penalties include possible fines and disciplinary action by the state Medical Disciplinary Board. In addition, physicians could lose their medical liability coverage. Most medical malpractice insurers, including ISMIE, lapse coverage for the time physicians practice without a valid license.

To avoid these repercussions, physicians who have not renewed their licenses must immediately send their completed renewal forms, along with full payment, to the Illinois Department of Professional Regulation. For physicians renewing now, a $100 late fee applies. The cost of a standard three-year, in-state renewal, including the late fee, is $400; out-of-state renewals are now $700 with the late fee. If physicians misplaced their renewal packet or never received one, they may contact the department at (217) 782-0458 to request forms. Doctors should allow ample time for mailing and processing. ■

GUEST EDITORIAL

Communication with a capital C

By Harold L. Jensen, MD

Language most showeth a man; speak that I may see thee.

– Ben Johnson

While raising our children, communication is a central concern. When they are infants, we are impatient for the babbling to become meaningful. By the time they reach three years of age, we sometimes pray for silence. And when they reach their teens, we are treated to sullenness and selective deafness. Communication, if defined as a two-way street, is a rare commodity in the parent-child dyad. Ideally, we instruct, and they, presumably, listen.

Physician-patient relationships of the past often resembled parent-child relationships. But physicians trained since about 1950 have been immersed in "scientific medicine," a concept fueled by the heady realization that, for the first time, physicians could indeed cure their patients. Data acquired by increasingly sophisticated equipment provides confirmable facts; this is in contrast to the "soft" data physicians previously extracted by questioning their patients. Once a terse physician interrogation yielded enough patient impressions to construct a working diagnosis, the patient could be, and was, ignored.

Physicians were trained to maintain dignity and distance. One just didn't sit on patients' beds, denigrate them by using their first name or touch them beyond the data gathering of physical examinations.

How things change! Communication, like Motherhood, is now capitalized. Now that there are enough physicians for patients to have a choice, we have found that "patient satisfaction" is necessary to maintain a stable practice. Unhappy patients have become activists. Discontented patients, at best, find other physicians with whom they can communicate; at worst, they punish the inattentive doctors with lawsuits.

Further, studies are accumulating to show that good communication between physicians and patients results in better clinical outcomes. The diagnoses are more accurate, and the courses of treatment are shorter and easier. Then, when the inevitable error or failure to improve occurs, the physician-patient relationship fostered by good communication can bridge patients' attendant anger or disappointment.

A recent market study asked 1,000 patients what traits they looked for most in a physician. Of the 11 attributes listed, time and explanations provided by their doctor ranked No. 1. In other words, patients want physicians to spend more time educating them. We should remember that the core meaning of the word "doctor" is "teacher."

Another study asked physicians to estimate how much time they spent providing patients with information during a typical 20-minute visit. Their answer was 10 minutes. In reality, however, the study revealed that these same physicians spent only about one minute giving information to patients. If we consider that only 25 percent of what we hear is retained and 20 percent of that is misunderstood, the magnitude of our ineptness at communicating with patients becomes more apparent.

Patients and their relatives are typically stressed during an illness. They are anxious and need to be heard. An important part of communication is listening carefully. By doing so, physicians gain an opportunity to allay groundless fears and clarify what the patient is trying to express. In addition, physicians may pick up important clinical information. Unfortunately, just as we, as parents, frequently try to control our children, so do we, as physicians, often control the conversation with patients. On average, we interrupt our patients after the first 18 seconds. By interrupting patients' descriptions of their first symptom (typically patients have between one and five symptoms), fewer than one-fourth of patients complete their first thought, and only half explain all their symptoms. Furthermore, male physicians tend to interrupt their patients more often than do female physicians. This could be one reason why more and more patients say they prefer female doctors.

Some communication techniques, such as the following, are easy to learn:

- Interrupt only to keep the discussion focused.
- Use open-ended questions, rather than those that can be answered yes or no.
- Paraphrase patients' descriptions of their problem and symptoms. Doing so conveys a message of, I'm paying attention. It also provides an opportunity to clarify misunderstandings.
- Ask patients to summarize their understanding of your instructions or recommendations, and follow up with written instructions.
- Use lay terms. If the goal is understanding, let's communicate in language patients can easily understand.
- Keep in mind that 80 percent of the basis for our feelings about other people can be attributed to nonverbal messages. Body language, too, is a communication skill that we must learn.
- Set time aside to instruct patients yourself, or delegate a nurse as your communication surrogate. Your office systems are set up to prevent interrupting your schedule. But these same systems can also become barriers to concerned patients who need instruction.



Dr. Jensen *is chairman of the ISMIE Board of Governors and a Harvey internist.*

I think the need is clear for physicians in general, and male physicians in particular, to develop communication skills that will help ensure better outcomes, build full practices and avoid the structured and painful communication of courtrooms.



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ISMIE Update

Why we can't afford to ignore tort reform

PAGE 10

Time is running out to renew your license

PAGE 7

When medical records are destroyed

Physicians should know how to protect themselves now in case their office records are ruined. By Gina Kimmey

Unfortunately, physicians' offices are not immune to fire, theft or myriad natural disasters. That was especially evident this summer, when Mississippi River flooding in western and southern Illinois left many homes and businesses, including doctors' offices, underwater. In some cases, critical medical documentation was lost. Although losing medical records is serious, physicians can rebuild their filing system after a loss and take routine precautions to minimize potential damage.

Risk managers consistently stress the importance of maintaining accurate and complete medical records. Doing so is integral to good medical practice and liability protection, said William Rogers, an attorney with Bollinger, Ruberry & Garvey in Chicago.

Some physicians believe that once the statute of limitations has expired they can get rid of their older medical records.

"Some physicians believe that once the statute of limitations has expired they can get rid of their older medical records. But in some cases the statute can be almost infinite," Rogers noted. "And it can be very helpful to the physician to have those records available, if needed, to assist in the defense of a malpractice claim.

"The unfortunate problem is that in daily life we have fires, floods, earthquakes, avalanches, whatever, and records are lost, [or] sometimes they are stolen," Rogers continued. As a protection, he suggests that physicians make master lists of their records, indicating the content of those records and their location. The list should be kept in a secure place, separate from the records themselves. If office records are destroyed, physicians would then note on the master list when and how the records were destroyed, Rogers said.

If files are destroyed, physicians should tell their patients the medical records are gone, said Jeffrey Glass, an attorney with Hinshaw, Culbertson, Moelman, Hoban & Fuller in Belleville. "For one thing, this protects the physician if he or she is ever sued and asked for the records. It will be clearly understood and stated on record that you notified the patient that the records were lost, and it would ameliorate any impression that you hid the records."

When you notify patients that their records have been lost, you should also tell them that you will have to take a thorough history during their next office visit, Glass added. "The records should be reconstructed immediately, to the best of the physician's ability."

AFTER A FIRE swept through his office building in 1989, Highland Park internist John M. Sultan, MD, was faced with reconstructing the records of several of his patients. Although firefighters placed tarps over the cabinets containing his patient files, Dr. Sultan said the tarps didn't protect all of the records from water damage. In addition, the charts for the 20 patients scheduled for that day were completely destroyed.

"My assistants spent five weeks in my garage with two Xerox machines, reconstructing the files that [received] water damage," said Dr. Sultan. "Luckily, the hospital had records on some of the patients, which we were allowed to use. And then we took complete his-

(Continued on page 12)

MALPRACTICE ROUNDUP

Patient's negligence deemed irrelevant

As reported in *Medical Malpractice Law and Strategy*, patients' failure to follow their doctor's advice should not be considered when determining fault for an injury allegedly caused by previous medical negligence. In 1982, a patient suffered a major heart attack and was treated for severe arterial disease. His physician instructed him to take several precautions, which evidence showed he failed to do.

In 1987, the physician saw him again for chest pains and released him. Soon after, the patient experienced more chest pain, and when he returned to the hospital, he died.

The trial court instructed the jurors to assess a percentage of fault to the patient if they believed that since 1982, the patient had failed to follow his doctor's advice. The jury found the patient 93 percent at fault, resulting in a verdict for the defendant-physician.

A Missouri appeals court overturned the verdict, however, stating that conduct occurring five years before the alleged negligence could not be a proximate cause of the 1987 injury. The court ruled that for the patient's negligence to be considered a proximate cause, his actions must have been "simultaneous and cooperative" with the physician's alleged negligent act. The patient's disregard for doctor's orders in 1982 was deemed too distant from the 1987 incident to be considered proximate cause, the appeals court said. ■

Patient misdiagnosed with lung cancer

After suffering from respiratory problems, a patient was admitted to a Missouri hospital for tests, according to *The Malpractice Reporter*. After studying the biopsy results, one pathologist found interstitial pneumonitis and lung cancer, while another pathologist said he was uncertain of the diagnosis. Because the two physicians could not agree on a diagnosis, a sample was sent to an expert in North Carolina.

In the meantime, the patient's oncologist informed the patient and his family that the patient had cancer and had only three weeks to live. On the oncologist's recommendation, the patient underwent one chemotherapy treatment, which was followed by extreme nausea, debilitation, weight loss and abnormal blood counts. Four days after the treatment, the North Carolina expert issued his report, stating that only interstitial pneumonitis, not lung cancer, was present.

Two years later, the patient died from interstitial pneumonitis. The family filed suit against the oncologist, alleging that he misdiagnosed the cancer and treated the patient with chemotherapy even though the cancer diagnosis was in doubt. The jury found in favor of the physician. However, the trial judge granted a new trial based on the testimony of the expert witness, who said the oncologist's treatment failed to conform to accepted standards of care. The expert also testified that administering chemotherapy when the physician knew the biopsy slides had been sent for an outside review amounted to a "failure to exercise that degree of skill and learning that an ordinarily careful and prudent physician would have exercised." ■

Florida court upholds caps

A recent Florida Supreme Court decision established that caps on noneconomic damages in medical malpractice actions would not violate the right of access to courts under the state's constitution, as reported in *Medical Malpractice Law and Strategy*. The ruling upholds Florida's cap on pain and suffering and other noneconomic damages in medical malpractice suits. Florida law allows either party in a medical malpractice action to request arbitration. With arbitration, noneconomic damage awards will be limited to $250,000. If the plaintiff refuses arbitration, noneconomic damages will be held to $350,000. However, if the defendant refuses arbitration and insists on a trial, no cap will apply. ■

Why we can't afford to ignore tort reform

Medical malpractice liability costs contribute significantly to the U.S. health care bill. Swift reform is needed to bring relief to doctors and patients alike. By Sean Taylor Simpson

Not long ago, physicians were admired, venerated and even trusted. They enjoyed practicing medicine and could be proud of their profession. The sick – rich and poor, young and old – received high-quality medical care. And even though liability insurance was available at what today would be considered minimal rates, many doctors saw no reason to purchase this safety net. The system was not perfect, but it was effective.

Physicians today must play a different game; the rules have changed, and so have the players. Insurance rates have climbed steadily as jury awards have grown exponentially. Our litigation system has become tedious and time-consuming, and the high cost of liability insurance is reflected in the escalating cost of medical services.

All these factors have forced physicians – from high-priced specialists to rural family practitioners – to reconsider their career plans. Many doctors have left the medical profession altogether, fearing legal action or the cost of malpractice premiums, or because they are tired of performing an endless list of procedures simply to protect against possible litigation.

The malpractice crisis has become a Goliath, and it will take more than a tiny stone to slay this tyrant. Tort reform has been discussed in the past. However, discussing and passing needed reforms are two different animals.

During last fall's presidential election campaign, candidate Bill Clinton vowed to reform the medical malpractice system, to take disputes out of the courts and to reduce the number of unnecessary procedures ordered by doctors to protect against malpractice lawsuits.

Regardless of how the Clinton administration chooses to revamp our health care system, malpractice reform must be an essential aspect of containing health care costs. The Clintons are closely allied with trial lawyers – Bill and Hillary both are attorneys, as are 11 of 14 Cabinet members – so it will be interesting to see if caps on malpractice awards will be a significant piece of the health care reform pie. To paraphrase William Shakespeare, words are not deeds.

THE CALL FOR medical malpractice reform can be heard outside the hallowed halls of Congress and beyond the domain of the medical profession. According to a June 1991 Gallup Poll, 77 percent of American adults think malpractice lawsuits and malpractice awards contribute significantly to rising health care costs. The public apparently supports the plight of U.S. physicians: Only 27 percent of U.S. adults indicated that malpractice claims against doctors are justified; 54 percent said jury awards are too high; and more than 60 percent supported a ceiling on pain-and-suffering awards.

In response to the liability climate, many physicians have limited their medical practices, which has limited patients' access to health care services. One-third of U.S. physicians eschew certain areas of medical practice because of the high cost of malpractice insurance. Many health care providers refuse to perform certain procedures, and others are leaving the medical profession. Restrictions on access to care have most dramatically affected indigent and obstetric patients and those in rural areas. According to data contained in the American Medical Association's August 1992 *Medical Liability Project* report:

• Community health centers have cut services and are making patients wait longer for appointments because, from 1988 to 1991, liability insurance premiums increased from $30 million to $60 million. Ten percent of all federal funds allocated to community health centers are used to pay malpractice premiums. The National Association of Community Health Centers says at least 500,000 additional patients could be treated if money spent on liability insurance was diverted to patient care.

• In rural areas, family practitioners provide two-thirds of private obstetric care; however, 60 percent of family practitioners are eliminating obstetrics from their practices because of the litigation situation. Currently, more than 500,000 rural residents are without a physician to provide obstetric services.

During the 1980s, liability claims against physicians more than doubled. Doctors now have a 38-percent chance of having a liability claim leveled against them, and, if they perform surgery, the figure increases to more than 50 percent. In 1990, almost eight of 10 obstetricians were sued at least once, and many had survived three liability suits, according to the AMA.

INCREASING TORT COSTS are impacting overall U.S. economic output. Between 1933 and 1991, U.S. tort costs grew nearly 400-fold – approximately four times faster than the U.S. economy. The most explosive increase in tort costs came after 1950, when they grew by an average of 11 percent annually, while nominal economic growth averaged only 7.5 percent a year.

Tort costs reached a new high of $132.2 billion in 1991 and are expected to exceed $300 billion – more than 3.5 percent of the U.S. gross domestic product – by the year 2000. The U.S. tort system is already the most expensive in the industrialized world, consuming 2.3 percent of the GDP, more than 2.5 times the average, according to Towers Perrin, a leading international management consulting firm.

Of the $132.2 billion in tort costs, $102 billion was dedicated to insurance costs, while self-insurance made up $21.1 billion and medical malpractice accounted for $9.1 billion. The insurance costs included benefits paid to people alleging injury or damage by insured parties (58 percent); benefits spent on insured parties' defense and claim handling (18 percent); and insurance companies' administrative costs (24 percent).

Of the 58 percent allocated to third-party benefits, awards for economic loss made up 22 percent, awards for pain and suffering accounted for 21 percent, and 15 percent went for claimants' attorneys' fees.

The tort system provides both direct benefits such as economic compensation awarded for damages and indirect benefits such as economic costs attributed to avoiding litigation, of which defensive medicine is a large part. Both factors are primary reasons for rising U.S. health care costs.

From 1965 to 1985, medical liability losses increased an average of 20 percent a year, prompting extreme malpractice insurance crises in 1975 and 1985, according to Edward M. Wrobel Jr., a consultant for Tillinghast, a company that provides consulting and risk-management services to businesses, institutions and government agencies. "In the late 1980s, the growth in settlement costs moderated, and the frequency of claims fell to levels of seven to 10 years earlier," Wrobel added.

During the 1980s, the cost of liability insurance premiums grew faster than any other expense for health care professionals. The cost of physicians' liability

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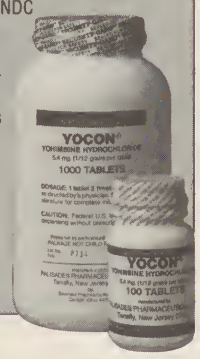
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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insurance paid by doctors and hospitals tripled, from $1.7 billion in 1982 to $5.6 billion in 1989. In 1991, premiums reached $9.2 billion – a 65-percent increase from 1989, according to the AMA.

How much does that cost the patient? An increase of 10 percent raises the fees physicians charge from 1 percent to 4 percent.

Considering that liability rates have more than quintupled in the last decade, producing a 6-percent to 22-percent increase in physicians' fees, it is no wonder health care costs are increasing.

HEALTH CARE PROVIDERS perform unnecessary medical procedures because they fear lawsuits or simply to meet patients' expectations. Some physicians conduct these tests so that they will not be accused of not doing enough for their patients.

In 1989, defensive medicine increased the nation's health care bill by $15.6 billion. In 1991, doctor-ordered defensive procedures accounted for $24.9 billion – a 60-percent increase – according to Levin/VHI, a health care consulting firm.

In 1991, 84 percent of U.S. physicians stated that the threat of malpractice suits influenced their decisions to order sometimes unneeded tests, according to an AMA study. This figure was the highest in survey history, up from 75 percent in 1989 and 78 percent in 1982.

Will defensive medicine, now taught in medical schools, be placed ahead of patient well-being? The Healthcare Leadership Council fears that without reform in the medical malpractice system, litigation avoidance will probably replace the Hippocratic oath as the cornerstone of the doctor-patient relationship.

A FAIR SYSTEM for adjudicating claims brought against medical professionals should permit all injured individuals access to the judicial system, decide claims quickly and make sure monetary awards benefit those who have been injured.

Nearly half of all physicians' defense costs are spent on cases closed without the plaintiffs' receiving any compensation. Only 6 percent of all individuals injured as a result of negligent care receive compensation, according to the AMA.

Contingency fees shut many injured parties out of the judicial process. When an attorney is paid only for winning, he or she might take a case only if it looks like a sure-fire win. Patients with legitimate but difficult-to-prove cases find American jurisprudence discriminatory.

The legal process is tedious and benefits neither party – innocent physicians are not vindicated promptly, and injured patients are not compensated quickly.

Injured parties receive no compensation or judgment in almost 60 percent of all claims brought against physicians, according to the U.S. General Accounting Office. Victims of negligence receive only 43 cents of every dollar spent on medical liability litigation as compensation, according to the Rand Corp. Less than 25 cents of every dollar goes to compensate injured parties for actual economic losses.

Perhaps it is politically incorrect to refer to attorneys as "ambulance chasers," but, according to a study in the *Journal of Applied Economics*, when competition among lawyers heats up or income sources shrink, attorneys actively seek malpractice cases. "A 10-percent increase in lawyers' excess time drives up the number of medical malpractice claims by 4 percent," the study stated.

Our medical malpractice system is expanding from all corners, and, like a runaway horse, it must be reined in if any good is to come from the legislative branch of the government in the near future. ■

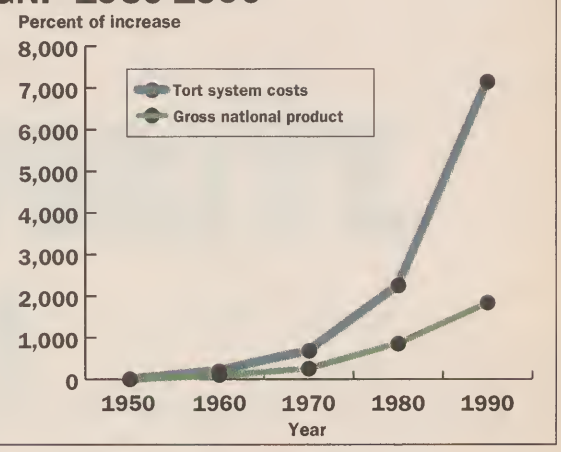
This article originally appeared in the June 1993 issue of Private Practice. *It is reprinted with permission.*

U.S. tort costs vs. GNP 1950-1990*

U.S. tort costs have increased from less than half a billion dollars in 1933 to $132 billion in 1991. In addition, between 1950 and 1990, tort costs in this country rose at nearly four times the rate of the nation's gross national product.

Source: Tillinghast

* Numbers are plotted as percentage of change from 1950.



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Medical records

(Continued from page 9)

tories from the patients all over again."

Although Dr. Sultan was able to reconstruct or salvage his patients' files, other physicians might not be as fortunate. That's why maintaining a master list is critical in case physicians are forced to defend a malpractice claim, Rogers noted.

More and more, Illinois courts are recognizing a theory called spoliation of evidence, Glass said. "The argument is that the loss of evidence is an injury in and of itself." The theory has been applied to the medical arena in an appellate case in which a hospital was found liable because it had destroyed a patient's X-rays. According to Glass, the case against the defendant-dentist was settled for half the damages the plaintiff was seeking. Then the plaintiff sued the hospital, which the court found liable for the other half of the damages sought by the plaintiff. The court stated that the absence of the X-rays cost the plaintiff his original case.

Rogers also cited a particular instruction given to juries: If one party has lost evidence, the jurors may infer that the evidence was unfavorable to that person. However, to apply that instruction, jurors must believe there is no reasonable excuse for the party's failure to provide the evidence. That is why it is so important for physicians to indicate on a master list what happened to any lost or destroyed records, Rogers said.

In a recent case, a defendant was unable to produce the plaintiff's records, because some of the doctor's records were damaged in a flood, Rogers said. But the physician had no documentation to substantiate his claim. "The plaintiff was able to do some easy cross-examination, asking why only portions of the records were missing and why those portions seemed to be the only treatment concerning the case.

"If the defendant had just had a master list, he would have been able to say, 'Well, here is the date of the flood, and here is what I lost. Not only did I lose this patient's records, but I lost the records of 50 other patients as well,'" Rogers continued. "In a case where credibility is important, why give the other side an easy argument on credibility? That's the importance of maintaining records and maintaining them for a lifetime." ■

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STOP SMOKING

Physicians help patients kick butts

People may need some support from their doctor to cut out tobacco.

BY JANICE ROSENBERG

By now, most smokers have received the message: They know cigarettes are bad for them. But that knowledge alone hasn't been enough to make them stop. In addition to the facts, they need encouragement and support from their physician. By taking an active role in helping patients stop smoking, physicians contribute directly to the health of not only their patients, but others who are exposed to secondhand smoke. Studies of smoking interventions show that physicians' advice or brief counseling alone can result in cessation rates of 5 percent to 10 percent, according to the U.S. Department of Health and Human Services.

"If there was ever a universal recommendation for all doctors to make to all patients it's that they should quit smoking," said Luke L. Burchard, MD, a family physician in Mattoon. "A lot of physicians still don't talk to patients about smoking or any other lifestyle-related problem. It needs to be a priority."

The American Cancer Society reports facts and figures regarding smoking that underscore its status as a major health issue. Currently, there are about 46 million smokers in the United States, and about 50 percent became regular smokers before age 18. There are 434,000 premature deaths per year directly related to smoking. Smoking also causes about 30 percent of all cancers and is responsible for more than 87 percent of lung cancer cases. In addition, smoking is associated with conditions ranging from colds and gastric ulcers to chronic bronchitis, emphysema and cerebrovascular disease. The cost of smoking runs about $65 billion per year, according to estimates by the U.S. Congress Office of Technology Assessment.

Every cigarette takes seven minutes of a smoker's life, adding up to 5 million years of potential life that Americans lose to cigarettes each year, according to the U.S. Centers for Disease Control and Prevention.

PHYSICIANS SHOULD SERVE as role models for their patients, said Joseph L. Murphy, MD, chief of the section of general internal medicine at Saint Joseph Hospital & Health Care Center in Chicago. He called doctors who smoke "rare birds." The actual figure is less than 10 percent, according to the American Cancer Society.

Dr. Murphy has devised his own approach to smoking cessation. First, he explains why the patient should quit smoking, tailoring his message to the recipient. He talks to older patients about shortened life spans, to young athletes about loss of wind and stamina, to teenage girls about discolored fingernails and bad breath, to post-adolescent women about wrinkles around their eyes and the dangers of smoking during pregnancy, and to parents about the effects of secondhand smoke on their children.

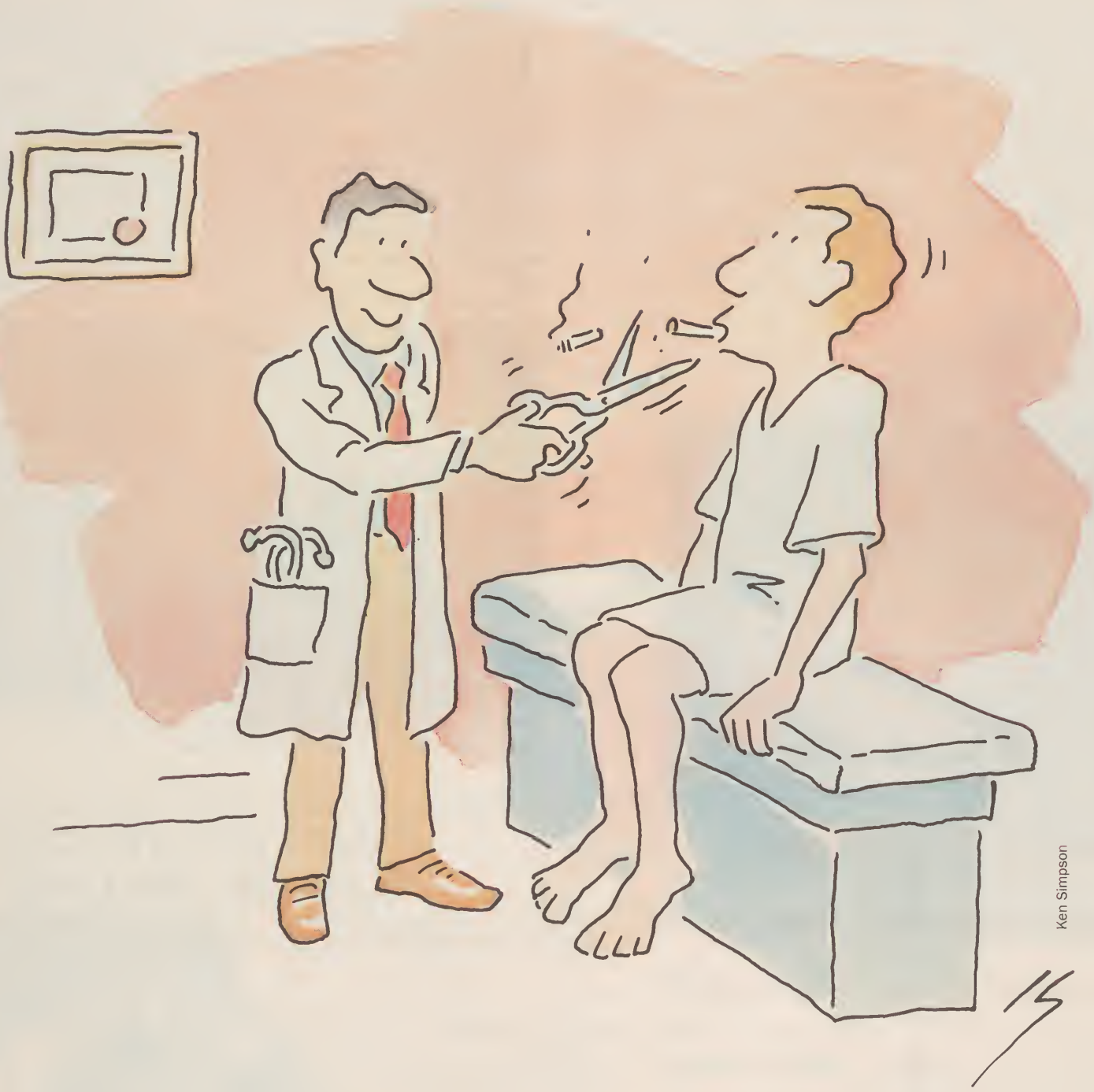
"I'll try every possible way to get them to see that smoking shouldn't be in their lives," he said. "I'll tie it to their family situation or the effect on co-workers."

Next, Dr. Murphy tells patients that once they want to quit smoking, they can. Then he encourages them to say that they will quit. And finally, he tries to help them make a commitment as to when they'll stop. "That's the toughie," he said. "I have them pick a day in the near future. During the time leading up to it, I advise patients to use a form of self-hypnosis, to tell themselves every day that they are going to quit, that they can do it."

THE AMA ENCOURAGES physicians to actively involve themselves with patients who smoke, according to Tom Houston, MD, director of the AMA's department of preventive medicine and public health. He said the organization recommends providing patients with information on smoking and carrying out four steps: ask, advise, assist and arrange.

Physicians can take the first step and ask patients

STOP SMOKING



Ken Simpson

about smoking at a first visit or when seeing a patient after a long interval. This should become as routine as checking patients' vital signs. "Mark the charts of smokers with big orange stickers that say 'smoking' to remind you to talk to the patients about smoking each time you see them," Dr. Houston suggested. "This tells the patients that the doctor is concerned and prepares them for the doctor to talk about it."

The next step is to advise patients about quitting, by stating clearly and unequivocally: As your physician, I must advise you to stop smoking now. Then discuss the proven dangers of smoking, such as increased incidence of heart and lung disease, bladder and prostate cancer, strokes, and premature aging of the skin. There is also some evidence of an increased likelihood of cataracts in smokers.

Physicians should next offer to assist patients with smoking cessation. For those who express a desire to quit, a date should be set – preferably one that coincides with an anniversary, birthday or national holiday. Some physicians ask patients to sign cessation contracts. Others ask patients to keep a smoking diary during the week or two prior to the quit date. The physician then reviews the diaries with patients to help them recognize and change behavior patterns associated with smoking.

Even patients who aren't ready to quit should be given educational and motivational materials. "Encourage patients to call you later for more information, call a [smoking cessation] hot line, or visit a class," Dr. Houston said. "And tell patients you'll be asking about their smoking again."

After talking to patients who smoke, physicians should arrange follow-up appointments. The AMA suggests that physicians appoint a nurse or office worker to serve as a smoking-cessation coordinator, keeping in touch with patients who've quit and reminding them that there's no substitute for quitting.

Whatever technique is used, physicians should approach smoking cessation in a caring way. "If doctors appear [to be] threatening or condescending, they won't get the patient to change," said Dr. Burchard. "If the message is given in context and seriously, with patience and understanding, then it's heard."

While some patients are able to stop smoking "cold turkey," others request a nicotine patch or gum. "Tobacco substitutes aren't one-on-one," said Stanley

(Continued on page 16)

Stop smoking

(Continued from page 15)

M. Bugaieski, MD, clinical associate professor of medicine at the University of Illinois College of Medicine in Peoria. "You have to explain to the patient that they aren't here to take the place of a cigarette. They're here to keep you from being nervous and sweaty. And you have to explain that they can't smoke and wear a patch, too."

Dr. Bugaieski doesn't agree with drug inserts that say the patch shouldn't be given to patients who have coronary heart disease or who have experienced a stroke or are pregnant. "These are the patients who should take them. There are 2,000-plus materials in the tobacco smoke that you don't get with the patch. The patch is just nicotine."

BATTLING THE TOBACCO industry's pervasive advertising is a tough job. Teenagers are especially susceptible to the images of glamour and sophistication shown on billboards, in magazine ads and at tobacco company-sponsored sporting events. To help combat this onslaught, "Doctors Ought to Care" (DOC) was founded 15 years ago. "The group's goal is to point out that unless society does something about the outright promotion of unhealthy habits to young people, we'll never have a healthy society," said Dr. Burchard, who is the group's president-elect.

DOC is a national organization with about 10,000 members, most of whom are physicians. Members focus on teaching young people in their communities about healthier lifestyles. DOC also takes aim at athletic events sponsored by cigarette companies, noting that there are as many as 2,000 cigarette messages per race in the Daytona 500 alone. "Every NFL football stadium has a Marlboro sign in the end zone," Dr. Burchard said. The signs are highly visible during televised games. "As part of enforcing the law against cigarette ads on TV, DOC wants to get rid of these signs."

Over the last 10 years, DOC has also targeted the Virginia Slims tennis tournaments. "We've attempted to run our Emphysema Slims Tennis Tournament concurrently with theirs," Dr. Burchard explained. "Now the Virginia Slims tournament has been dropped in most major markets. Professional women's tennis has been picked up by *Family Circle* magazine, Campbell's Soup and other corporate sponsors. We've made this happen."

DOC cited a correlation between the tournaments and cigarette sales to teenage girls. "Girls smoke because they want to seem mature and cool," said Linda Hughey Holt, MD, chairman of the Ob/Gyn department at Rush North Shore Medical Center in Skokie. "But by the time they're past adolescence, they're using cigarettes as a stress reducer."

Because nicotine is known to be an appetite suppressor, some people – especially women – use cigarettes to control weight gain. "The challenge [for physicians] is to counsel them on risks and get them to quit, but also to support the women themselves and not lay some terrible guilt on them if they can't quit," Dr. Holt said.

Pregnancy is a window of opportunity for smoking cessation, Dr. Holt said. "You have to have low self-esteem and be very self-destructive to want to smoke during pregnancy. Smoking can lead to low birth weight, birth defects, growth and school problems, asthma and childhood illnesses."

Dr. Holt also noted that many smokers are grateful for the elimination of smoking in the workplace because it has helped them cut down. "I encourage people who smoke to do so only outside their homes. If you have to go out and stand on the porch in the sleet, that cuts down on the desirability of smoking. It also protects your kids from secondhand smoke."

Although physicians can play a big part in prompting their patients to quit smoking, some patients will return to cigarettes. "Find out what made your patients go back, then outline a better program when they're ready to try again," said Dr. Burchard. "Point out to them that the single most important part of getting the job done is their desire to quit." ■



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Public health center receives private help

EXPANSION: A public-private partnership is improving health care in one medically disadvantaged neighborhood. By Gina Kimmey

[CHICAGO] Addressing the primary care needs of residents in its medically underserved neighborhood was the goal of the Dr. Jorge Prieto Health Center when it opened in 1975. But the clinic has not accepted a new patient in the last five years. Located in the predominantly Hispanic community of Little Village on Chicago's southwest side, the clinic serves more than 27,000 patients per year and can't accommodate any new patients. More than 200 patients are turned away each month, according to a spokesperson for Lutheran General Health Services in Park Ridge.

In an effort to help the clinic treat more patients, representatives from Cook County government, LGHS and the clinic's community advisory board unveiled a 10-year, $3.1 million project in August to open a new, larger health center. The increased clinic space will enable the health center to expand its primary care medical services, according to partnership representatives.



Verla Gillmor

Patients line up for care outside the Dr. Jorge Prieto Health Center, which will move to a larger facility late next year and expand the primary care services it offers.

A pool of public and private resources will fund the clinic's relocation to a 15,000-square-foot facility owned by the Hispanic Housing Development Corp., said an LGHS spoksperson. The new clinic, expected to open in late 1994, will be large enough to accommodate 50,000 patient visits each year. In addition to primary care and preventive services, the clinic will provide mammography, sonography and minor surgical procedures, according to Cook County Hospital officials.

"The clinic is designed as a family practice model. We want to take care of the whole patient and the entire family," said Tom Gavagan, MD, head of the ambulatory care division of Cook County Hospital's family practice department. Currently, patients turned away from the clinic are forced to go to the already overcrowded Cook County Hospital emergency room, Dr. Gavagan said. "These patients should be able to get primary care in their own neighborhood, not the hospital ER."

The clinic is operated by the Cook County Bureau of Health Services, and staff physicians and residents are provided by the Cook County Hospital family practice department. The clinic is a key training site for the hospital's family practice residents, said Dr. Gavagan. LGHS is also considering starting a medical residency rotation at the clinic for Lutheran General family practice residents.

The clinic, originally called the South Lawndale Health Center, was named for its founder, Jorge J. Prieto, MD, who served as chairman of family practice at Cook County Hospital until he retired in 1985. Reflecting on the clinic's opening, Dr. Prieto said: "I asked myself, Why can't we have good family practice health centers out in the neighborhoods? This health center has been a realization of that dream." ■

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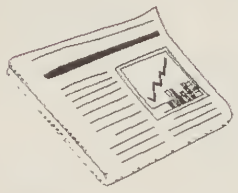
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Assisted suicide

(Continued from page 1)

life when that intent is clear. For a conviction for assisting a suicide, the maximum penalty is a three-year jail sentence and a $10,000 fine. In cases of unsuccessful suicides, individuals who aid the suicide attempt face misdemeanor charges. The provisions in H.B. 819 were added to standing legislation stating that coercing a person to commit suicide without providing the means is considered a Class 2 felony.

Although H.B. 819 does not specifically mention physicians, the bill was introduced to prevent Michigan physician Jack Kevorkian, MD, from providing "self-termination" services to patients in Illinois, said bill sponsor Rep. John Sheehy (D-Tinley Park). "The basis for this legislation [was] to tell doctors who are thinking about providing suicide machines to people that Illinois is not the place."

As of Sept. 29, Dr. Kevorkian had either attended or assisted the suicides of 18 terminally ill Michigan residents. The last three deaths occurred after Michigan's assisted-suicide law became effective on Feb. 25, 1993.

H.B. 819 is similar to the Michigan law. The Illinois law contains a provision stating that compliance with the Illinois Living Will Act, the Health Care Surrogate Act or the Powers of Attorney for Health Care Law would not be considered inducement to commit suicide.

The Michigan State Medical Society had opposed the original version of the Michigan bill when it was introduced in the state legislature. MSMS removed its opposition after the bill was amended to include medical society language protecting physicians who prescribe pain medication. "There was some concern [among Michigan physicians] about physicians' ability to provide adequate pain control" in the unamended legislation, said David Fox, an MSMS spokesperson. Physicians feared the law would hold them liable if one of their patients died after taking prescribed pain medication, even if suicide was not intended, Fox said.

The Michigan law established a maximum penalty of a four-year jail sentence and a $2,000 fine for individuals convicted of aiding a suicide attempt. The law defines assisted suicide as "provision of physical means by which a person attempts or commits suicide" or "participation in a physical act by which a person attempts or commits suicide."

In addition to banning assisted suicide, the Michigan law established the Michigan Commission of Death and Dying. The commission comprises 22 members representing various Michigan health care interests, including MSMS, the American Civil Liberties Union of Michigan, the Hemlock Society of Michigan and the Right to Life of Michigan, Inc. The legislature charged the group with developing guidelines for crafting future assisted-suicide legislation after the current law sunsets in May 1994, said Howard Brody, MD, a commission member and chairman of the MSMS Bioethics Committee. Recognizing that they rushed legislation into place, lawmakers wrote the sunset provision into the law to allow adequate consideration of the commission's recommendations, which are due by June 1994.

In May 1993, the Michigan ACLU challenged the assisted-suicide law on behalf of several terminally ill cancer patients and some physicians. A circuit court judge subsequently ruled the law unconstitutional. However, an appeals court stayed the lower court ruling while it reviews the case, Fox said.

Shortly after the ACLU case, the commission began its deliberations. Dr. Brody said early in the process, members voted on a motion that would have directed the group to base its recommendations on the concept that assisted suicide should be legal. Ten commission members voted for the motion, nine voted against, and two abstained. "There was a fair amount of sentiment among commission members for having assisted suicide as an option," Dr. Brody said. "I can't say that's how it will come out. Many members believe there is something to be learned from ongoing dialogue." ■

Clinton reform plan

(Continued from page 1)



• Within five years of the system's implementation, 50 percent of physicians must be trained in primary care. Residency slots will be allocated by the U.S. Department of Health and Human Services accordingly.

• Antitrust laws will be loosened somewhat to allow physicians to negotiate prices in some cases, if the providers share the financial risk. Providers will still not be able to boycott.

• Current Medicare and Medicaid anti-kickback rules will be extended to all health plans.

• Some malpractice reforms are included, such as caps on attorneys' fees, but the substance of these reforms has already been enacted in Illinois. The proposal does not include caps on noneconomic damages, and it calls for allowing the public to access the National Practitioner Data Bank records of repeat offenders and creating standards based on practice guidelines. ■

Editor's Note: For ISMS' reaction to the president's plan, see page 6.

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Evanston Hospital

(Continued from page 1)

Hospital Corp. senior vice president for corporate relations. The network is not technically a merger of the four entities, as was previously reported in *Illinois Medicine*. Instead, it is an affiliation that enables each institution to retain its own leadership and budget.

IN AUGUST, the Evanston Hospital medical staff voted 200-1 not to join the network unless compromises were made allowing the hospital leeway to back out of the affiliation during the first five years, Dr. Sprang said. In addition, 450 professional staff members petitioned the board to vote against joining the network.

But the medical staff "felt comfortable" negotiating with the board to ensure the hospital continues providing necessary services to area patients, Dr. Sprang said. "Our concerns about the structure [of the network] made a significant impression on the board. The board wanted to go forward together. Our concern was that once we were in, there would be no way out."

According to Dr. Sprang, if the network accepts Evanston Hospital Corp.'s conditions for joining, the institution would be locked into the network for the next 12 months, but would have a five-year option to leave the network within 60 days after the 13th month. However, conditions for withdrawal would be limited, Loveland said. The Evanston board is currently negotiating terms of withdrawal and other conditions with the network, Loveland said.

> *Networks can provide more services over larger geographical areas. It's going to be difficult for individual hospitals to compete without networks.*

Among the other conditions the hospital set are that each network member must approve the arrangement by agreeing to all conditions established by other member institutions; Evanston Hospital must be allowed to maintain its current academic relationship with Northwestern University Medical School; Evanston Hospital must retain the right to appoint its medical leadership; and each of the affiliate hospitals must receive two permanent seats on the network board.

THE NETWORK'S original plans had called for a network board independent of the four partners with authority over all hospitals, Loveland said. But before the Sept. 10 vote, the network agreed to concede two seats to each of the founding partners, which meets the Evanston requirement.

Still, physicians are wary that this network "superboard" could wield more power over time. "Hospital strategies must be approved by the network," Dr. Sprang said, adding that although hospital operations and assets currently do not fall under the domain of the network, the network board could gain significant power to eventually approve or reject budget and procedural decisions.

The Northwestern Healthcare Network began in October 1989 as a loose affiliation among the four institutions. The network elected officers in February 1990 and developed its primary goal of creating a "pre-eminent and integrated health care delivery system for the Chicago metropolitan area and [becoming] a regional referral center for the Midwest." On Nov. 1, the network will enter the second phase of its development and begin operating as a legal entity.

Loveland cited the ability to negotiate with large health alliances and purchasing cooperatives as a primary benefit of network affiliation. "There is nothing prohibiting hospitals from contracting on a local basis." But future purchasing will likely be regional, and individual hospitals could be excluded from such ventures, he said.

"Networks can provide more services over larger geographical areas," Dr. Sprang said, explaining that hospitals in networks are better positioned to expand their patient bases. "It's going to be difficult for individual hospitals to compete without networks." ■

Council urges public health changes

RECOMMENDATIONS: A Metropolitan Planning Council study evaluates Chicago-area public health programs and advises changes. By Anna Brown

[CHICAGO] New study recommendations call for the Cook County Department of Public Health and the Chicago Department of Health to implement changes aimed at improving public health services in the Chicago area. The study, "Public Health: The Best Kept Secret," was conducted by the Metropolitan Planning Council's health committee and focused on "core functions" of area public health agencies. These include assessment, or identification of public health needs; policy development; and assurance, or public education efforts. The study revealed that most of Cook County's public health resources are dedicated to medical treatment, not necessary core functions.

Specifically, the study showed that Chicago-area public health departments "were not always consistent with practice standards" in assessment, policy development and assurance. The study defined assessment as the process used by public health agencies to identify, analyze and investigate community health problems. To act as leaders in the community, agencies also need cohesive policy development that enables them to advocate public health, build constituencies, set priorities and develop community action plans, according to the study. Adequate assurance requires agencies to inform and educate the public; guarantee that services are available to meet priority health needs; implement and evaluate programs; and manage resources, the study said.

"[Study] indicators show that the public health system in Cook County is not working effectively," said Eileen Kelliher, the council's senior planner for health care. "We recommend [the departments] take a closer look at core functions to meet national standards for public health." She cited infant mortality, sexually transmitted diseases and tuberculosis as significant county public health problems.

To help improve the county public health system's ability to address local needs, the committee made three recommendations. The first is to establish a countywide health authority to oversee public health and health care activities. Such an authority would provide the "continuum of care necessary to protect and promote public health, and prevent costly medical crises and inappropriate treatment," the committee's executive summary stated.

This recommendation is the most important, said Karen Scott, MD, CCDPH director and a member of the council's public health advisory group. Dr. Scott said she has seen overlap in agencies providing services such as immunizations and medical treatments. Although the departments "share in failures and successes," their different funding sources and lack of coordinated services make some programs redundant, while others are overlooked.

The council's second recommendation encourages partnerships among CCDPH, CDOH, the Suburban Tuberculosis Sanitarium District and suburban health departments. Other suggested partnership members include government agencies; the University of Illinois at Chicago School of Public Health; and private and nonprofit organizations involved with public health. Currently, "partnerships are rarely developed between government and private contributors to public health," the study stated. Such partnerships could become excellent resources for student training, data and research sharing, and continuing education, the summary noted.

The final recommendation calls for local health agencies to make changes to meet practice standards. The study said the departments' assessment programs are not comprehensive and "do not always achieve the necessary balance between quantitative and qualitative input."

Local public health statistics compared with national goals

Public health indicators	Chicago 1990	Suburban Cook County 1990	U.S. 2000 Goals
Infant mortality (rate per 1,000 live births)	15.6	9.7	7.0
Lead poisoning*	25% (1992)	16.78% (1992)	Reduction
Children age 2 with completed immunization series	29%	N/A	90%
Syphilis (rate per 100,000)	123.8	22.4	10
Gonorrhea (rate per 100,000)	876.2	120.3	225
AIDS (cases reported)	828	138	800 (cases per 100,000)
Salmonella (rate per 100,000)	40.8	20.6	16.0
Lung cancer deaths (rate per 100,000)	52.7	25.7 (death from chronic lung disease)	42.0
Tuberculosis (rate per 100,000)	25.3	6.075	3.5

Source: Illinois Department of Public Health

*** Percentage of those screened who tested positive under the 1992 CDC guidelines of 15 mcg/dl. Suburban Cook County figure is based on state estimate of number of children tested.**

The study also showed that the Chicago Board of Health and the Cook County Board of Commissioners – the primary public health policy-makers for Cook County – are "not effective in public health policy development and do not provide effective links to the community."

Instead of allocating funds for assurance programs, more than 80 percent of the CCDPH and CDOH budgets are allocated for personal health programs, the council said. Most of those funds are designated to pay for medical treatment for individuals in clinics rather than to support communitywide public health programs. The study said that although the departments provide some public education through media and health education programs, they do not have the resources to devote time to individualized patient education during clinic visits. Neither department evaluates program effectiveness, the study stated.

Dr. Scott applauded the study and its recommendations, noting that several of the suggested changes are already taking place. "We're making the best use of limited resources, and our ability to work together [with other public health agencies] has greatly improved." ■

Self-referral

(Continued from page 1)

care, or any other insurer, for designated health services that are covered by Medicare and provided in a facility owned directly or indirectly by the treating physician, or in which the physician has a financial interest, the ISMS analysis states.

The law does allow some exceptions, such as certain in-office ancillary services. Also, services provided by a doctor who is a member of the same group practice as the referring physician are permissible. This exemption allows physicians and physician groups to continue to refer for routine in-office services. Physicians may also refer patients to companies in which they own an interest, if the company is traded on a major exchange for which daily quotations are published. The company must also have stockholder equity exceeding $75 million; previously a company needed to have $100 million in total assets.

Medicare-designated rural areas are also still exempt "if substantially all of the designated health services furnished by such entity are furnished to individuals residing in such a rural area." ISMS analysts also said the law permits referrals to physician-owned hospitals, provided the referring physician owns shares in the entire hospital, not just in particular departments, such as a laboratory or MRI.

Many of the provisions regulating other compensation agreements are virtually unchanged from the previous law, according to ISMS analysts. These include agreements such as rental or lease of office space and equipment, or physician recruitment. The law had defined those agreements as safe-harbor financial relationships exempt from the ban on referrals for clinical laboratory services. Now safe harbors apply to referrals for designated health services. There is no change in the law that went into effect Jan. 1, 1992, restricting referrals for clinical laboratory services.

Violating the anti-kickback provisions is classified as a felony and is punishable by fines of up to $25,000 and a maximum of five years in prison. Under federal law, the U.S. secretary of Health and Human Services has the authority "to develop rules as needed to protect against program or patient abuse," ISMS advisers said.

Physicians with questions about OBRA '93 and the new self-referral and anti-kickback rules may call the ISMS health care finance division at (800) 782-ISMS or (312) 782-1654, ext. 1168. ■

SIU names new dean

[CARBONDALE] Southern Illinois University President John C. Guyon, PhD, appointed Carl J. Getto, MD, dean and provost of the SIU School of Medicine on Aug. 30. Set to begin full-time duties in January, Dr. Getto will succeed retired dean Richard H. Moy, MD. Dr. Getto was vice dean and a professor of psychiatry at the University of Wisconsin Medical School and associate dean and director of clinical affairs at the UW Hospital and Clinics in Madison.

"I am delighted that Dr. Getto has agreed to accept this challenging position," Dr. Guyon said. "In addition to his considerable experience at the University of Wisconsin, he brings a commitment to continuing the primary care mission of SIU's medical school."

Dr. Getto's administrative experience includes serving as acting dean of the UW Medical School, acting chair of the school's psychiatry department, director of the UW Pain Treatment Program and director of Psychiatric Consultation Service for UW and Middleton Veteran's Administration Hospital. He is a diplomate of the National Board of Medical Examiners, a fellow of the American Psychiatric Association and an examiner for the American Board of Psychiatry and Neurology. Dr. Getto is board certified in psychiatry and neurology; he received his medical degree in 1972 from the Loyola University Stritch School of Medicine.

"SIU is in an excellent position for the health care reform of the '90s and can use its many innovative strategies to continue meeting its mandate to educate physicians for Illinois," Dr. Getto said. Among the medical school's strengths, he listed a "unique and well-respected medical education curriculum" and "considerable support in Springfield, Carbondale and many other downstate communities." ■



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The Physician HELPline is a confidential physician-directed advocacy service linking mentally or physically impaired physicians and their families with helpful resources. Call the 24-hour Physician HELPline when someone you know needs help.

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)
CONTRAINDICATIONS
Hypersensitivity to any component of this medication.
Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).
Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.
WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.
As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.
Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.
Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**
The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**
PRECAUTIONS
General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.
Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.
Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SO 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SO 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.
Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.
Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.
Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.
Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)
Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.
Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.
Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SO 31,945 was not altered.
Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SO 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.
In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.
Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.
Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.
CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.
A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.
Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.
The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.
A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.
No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.
In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.
Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.
Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.
Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).
Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)
ADVERSE REACTIONS
Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.
Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug.

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.
The following effects have been reported with drugs in this class:
Skeletal: myopathy, rhabdomyolysis.
Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.
Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.
Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.
Reproductive: gynecomastia, loss of libido, erectile dysfunction.
Eye: progression of cataracts (lens opacities), ophthalmoplegia.
Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).
Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.
Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)
OVERDOSAGE
There have been no reports of overdoses with pravastatin.
Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the adjacent page.

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WHY PATIENTS SUE (PAGE 7)

HCFA DISCONTINUES PUBLIC RELEASE OF MORTALITY DATA

PAGE 2

Illinois Medicine

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John McNulty

THIRD-YEAR MEDICAL STUDENT Kristen Brown (right) picks up interviewing tips from consultant Bob Hultz during the ISMS Medical Student Section's seventh annual "Preparing for Residency Interviews" seminar Oct. 2 in Oak Brook.

Cancer Society urges doctors to recommend mammography

DETECTION: Physicians respond to a breast cancer awareness mailing. By Anna Brown

[CHICAGO] As part of its National Breast Cancer Awareness Month crusade in October, the Illinois Division of the American Cancer Society urged Illinois primary care physicians to recommend mammograms for all women age 50 and over. Division president Stephen F. Sener, MD, wrote to 8,000 physicians statewide advising them of the importance of mammography in the early detection and intervention of breast cancer.

In the mailing, the society also included reply cards for physicians to request further information and materials on breast cancer. To date, the response has been 10 percent. Such a high response rate is "unheard of in reply standards," according to an ACS spokesperson.

"While regular mammograms are important for women over 40, the risk of breast cancer increases with age," Dr. Sener said in his letter to physicians. "No matter what your specialty, the American Cancer Society asks you to recommend an

(Continued on page 13)

INSIDE

LifeSource donor notification under way

PAGE 3



State honors water systems with required fluoride levels

PAGE 6

DEPARTMENTS

News Briefs.....2

Commentary.....4

Calendar 5

ISMIE Update 7

Classifieds 11

Lead poisoning affects children statewide

TESTING: In the first 10 months of a mandatory testing law, 24,038 Illinois children have been diagnosed with lead poisoning. By Gina Kimmey

[SPRINGFIELD] Physicians should prepare to monitor and treat lead poisoning and discuss prevention measures as a result of a new law requiring children statewide to be tested for blood lead levels. Of the 175,000 children tested since Jan. 1, Illinois public health officials have identified 24,038 children suffering from lead poisoning, said a spokesperson for the Illinois Department of Public Health. Under the Childhood Lead Poisoning Prevention Act, the new law requires that all children under age 7 be tested for lead poisoning before entering day care, preschool or kindergarten.

Legislation to establish effective lead abatement programs is supported by ISMS House of Delegates policy as part of the Society's support for legislation regarding lead poisoning in children.

"We test children because they are growing and developing, so lead has an impact on them," said Terry F. Hatch, MD, president of the Illinois Chapter of the American Academy of Pediatrics. "The children are at the right age for us to be concerned, and the opportunity to test them is right there as they enter school."

The law was enacted after the U.S. Centers for Disease Control and Prevention recommended that all children be tested for lead poisoning. Previously, only children considered to be at high risk – predominantly inner-city children and those living in dilapidated housing – were tested, according to IDPH. But the CDC found that children in middle- and upper-class homes are at risk too, IDPH said.

(Continued on page 15)

Lead poisoning in children

Area	No. testing positive*
Chicago	20,543
Suburban Cook County	497
DuPage County	30
Kane County	283
Lake County	75
McHenry County	10
Will County	73
Downstate	2,527
Total	**24,038**

* 175,000 children tested statewide as of Aug. 31, 1993

Source: Illinois Department of Public Health

ISMS PERSPECTIVE

FIRST, DO NO HARM

No one has more to gain from meaningful health care reform than physicians and their patients. That's why Illinois physicians are taking active roles in the ongoing reform debate on center stage in Washington, said ISMS President Arthur R. Traugott, MD.

"Physicians are anxious to participate in reforming the nation's health care system," Dr. Traugott said. "But we want to make certain that any changes adopted actually improve, rather than impede, health care delivery."

Although the ISMS House of Delegates in April 1993 endorsed some of the same goals that President Clinton has expressed, the Society strongly disagrees with some of the ways in which the administration proposes to meet them, Dr. Traugott noted. "For example, ISMS supports the concepts of universal access, patient choice, insurance market reforms and employer-based insurance coverage. But while the Society agrees with these goals, in our conversations with lawmakers in Washington, we've encouraged them to act cautiously by reminding them that the health of the nation is at stake."

(Continued on page 6)

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HCFA discontinues public release of mortality data

HOSPITALS: HCFA will stop publishing hospital mortality information. By Gina Kimmey

[WASHINGTON] Hospital-specific mortality rates for Medicare patients are not an appropriate tool for consumers to use in choosing hospitals or measuring quality of care, said Bruce Vladeck, an administrator with the U.S. Health Care Financing Administration. Although these mortality reports have been increasingly regarded as consumer publications, Vladeck said the information is useless to consumers in its current form.

In an Aug. 17 letter to hospital administrators, Vladeck said the mortality reports are an important part of HCFA's efforts to improve the "effectiveness of medical practice and the quality of care provided to Medicare beneficiaries." But, he said, the data is best used by knowledgeable health care professionals in analyzing patterns and outcomes of care at various hospitals, not by consumers to make health care choices. Hospitals will continue to receive data for their own use, he said.

Published last year as the *Medicare Hospital Information Report*, HCFA had publicly released the data for the past six years. The report contains actual and predicted mortality rates for hospitalized Medicare patients who experienced a variety of conditions and received different treatments and procedures. As presented, the information is difficult for even educated consumers to interpret, according to an American Hospital Association spokesperson. In addition, it is not useful in determining hospital performance, AHA said.

"We agree with the decision and continue to encourage HCFA to investigate ways to make the information readily available and easier for the public to comprehend," said Tom Granatir of AHA's health policy division.

Many physicians also support HCFA's decision because of their concern that the data, as previously published, could be easily misunderstood by the public and misinterpreted by the media.

Although mortality data will not be released in book form this year, it is available to the public under the Freedom of Information Act. According to AHA, the data is widely used by purchasers and insurers.

The mortality data will continue to be released to Medicare-designated peer review organizations across the country. As part of HCFA's Medicare Hospital Information Project, PROs will use the data for national and local statistical pattern analysis projects. The analyses will then be used as part of HCFA's Health Care Quality Improvement Initiative, a campaign to improve the quality of care provided to Medicare beneficiaries. In the meantime, HCFA will continue to examine the data and develop methods of providing meaningful information to consumers, Vladeck said. ■



Ron Ackerman

WILLIAM GOSSMAN, MD, an emergency medicine resident at the UIC College of Medicine in Peoria (right), his wife, Shari, and daughter, Casey, discuss practice opportunities with a hospital exhibitor from Pontiac during the Doctors Fair Sept. 17 at Southern Illinois University School of Medicine in Springfield. The annual physician recruitment fair gives resident physicians and medical students an opportunity to learn more about Illinois towns in need of physicians.

Patients' presentation styles may affect evaluations

[CHICAGO] The way patients present their symptoms can substantially affect how physicians assess those symptoms, make diagnoses and order diagnostic tests, according to a study published in the Sept. 13 issue of the *Archives of Internal Medicine*. The Oklahoma University Health Sciences Center researchers studied 44 internists to determine whether patients' presentation style changed physicians' approach to evaluating chest pain.

The study divided the internists into three groups, with each evaluating a different version of the same scripted physician-patient interview. One group watched a videotape of an actress giving a "histrionic" presentation of her symptoms. The second group watched a videotape of the same actress giving a "businesslike" performance. And the third group read a verbatim transcript of the interview.

The study results revealed that 50 percent of the physicians who watched the businesslike performance chose cardiac diagnoses; less than one-third chose functional diagnoses. Of the internists who saw the histrionic performance, 73 percent made a functional diagnosis, such as panic attack or anxiety, and only 13 percent chose cardiac diagnoses. Participants in the third group were balanced among gastrointestinal, cardiac and functional diagnoses.

"Although physicians may evaluate patients who have the same history word-for-word and the same laboratory data, and whom they regard as having nearly identical likelihoods of coronary artery disease, [their] ultimate diagnostic approach can be profoundly affected by the patient's presentation style," the researchers concluded. They said more research is needed to determine whether variations in diagnostic approach based on a patient's presentation style are appropriate or biased. ■

Resident physician seminar slated for November

[CHICAGO] Illinois resident physicians can learn more about the business side of medicine at the ISMS Resident Physicians Section seminar "Paving the Way to Practice." Scheduled for Saturday, Nov. 13, the program will be held at ISMS headquarters in Chicago. Among the topics to be covered are employment opportunities, interviewing strategies, contract analysis and negotiation, and personal financial planning. Registration is limited to 60 participants. For more information, contact the RPS at (800) 782-ISMS or (312) 782-1654. ■

Chicago-area blood supply is low; donations sought

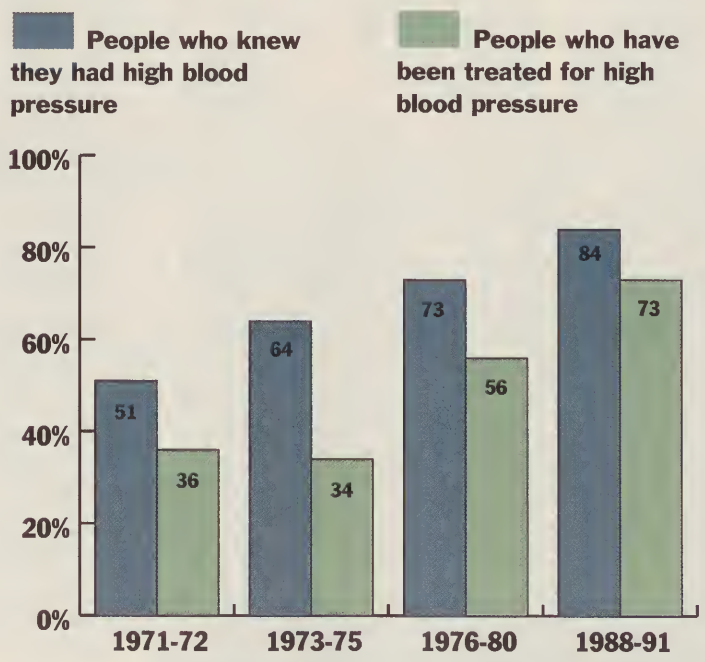
[CHICAGO] Blood donations are needed in the six-county region surrounding Chicago, according to officials of two area blood centers. Although all blood types are in short supply, types O and B have reached dangerously low levels, said LifeSource Blood Services and United Blood Services.

Blood centers nationwide have been faced with declining donations since June, officials said. To donate, contact LifeSource at (708) 298-9660 or United Blood Services at (312) 751-1701. ■

PHYSICIAN FACTS

Hypertension

As more people in the United States are diagnosed with hypertension, the number of those seeking treatment has also increased. Based on the estimated number of hypertension cases during the last 20 years, the following chart compares the number of people who knew they had the disease with the number who sought treatment for it.



Source: National Health and Nutrition Examination Surveys of the National Center for Health Statistics

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LifeSource donor notification under way

BLOOD: The results of a widely used screening test have left some blood donors with questions for their doctors. By Gina Kimmey

[GLENVIEW] Some Chicago-area physicians may find their offices inundated by patients requesting blood tests because LifeSource Blood Services is currently notifying 2,000 people that their blood reacted questionably to a screening test. The screening tests in question, conducted during the last six years, showed the donors' blood might be infected with HIV, hepatitis B, hepatitis C or syphilis. But because further testing proved the donors were not infected, LifeSource, like many blood bank organizations, did not contact the donors to discuss the test results.

"For years, we were trapped between notifying these individuals of the initial test results and unduly alarming them, or not providing them with information we possessed about their bodies that they may want to know," said Patrick Morand, LifeSource president. In the meantime, these donors continued giving blood that could not be used because of strict U.S. Food and Drug Administration rules stating that if a person's blood is considered questionable, future donations must be discarded.

In the spring, LifeSource's medical advisory board decided to contact all 2,000 donors with false-positive test results. During the six-month notification process, LifeSource will send 50 to 60 letters per week until all 2,000 donors are notified, said Morand. The letters thank the donors for giving blood and explain that their blood reacted abnormally to a screening test. In addition, they state that since no infection was confirmed, donors should contact LifeSource for further information and free retesting. However, some patients may prefer to contact their personal physician.

Richard J. Sassetti, MD, a Chicago hematologist and former chairman of LifeSource's medical advisory board, said physicians should encourage worried patients to be retested. "If your patient comes to your office asking questions about the screening test, that would suggest that he or she has some concerns," said Dr. Sassetti. "And while a negative second test doesn't mean that yesterday the patient didn't engage in some risky behavior, it may allay some fears associated with the initial test."

IN THE SIX YEARS LifeSource has been collecting blood, it has used eight tests to screen for transmissible diseases such as HIV, hepatitis B, hepatitis C and syphilis. One of these tests, ELISA, is widely used, inexpensive and quick, LifeSource said, but it relies on a broad screening method that can indicate an individual is HIV-positive, even when no infection is present. A negative ELISA test result is always accurate, LifeSource said.

If an initial screening yields positive results, LifeSource sends the blood to Abbott Laboratories in North Chicago for a confirmation test, Morand explained. Since 1987, results of confirming tests for 2,000 blood donations sent to Abbott came back negative, or infection-free, he said. Half of those blood donations tested HIV-positive with an ELISA test, and the other 50 percent was composed of false-positives for hepatitis B, hepatitis C and syphilis.

In 1992, the FDA changed its policy and instituted a "re-entry protocol" for using donated blood. The new regulation allows individuals who at one time received a false-positive test to be retested in six months. If the second test is negative, they can begin to donate blood again.

"We had encouraged the FDA for years to put something together to deal with this situation," said Morand. "So when the FDA came out with this program, we asked ourselves, What is the right thing for us to do?

"Notifying patients gradually allows us time to build mechanisms to provide counseling and free retesting," Morand added. "If I got a letter saying something may be wrong with my blood, I'd call right away. We just couldn't handle all 2,000 at one time."

According to Morand, LifeSource will continue notifying donors when an initial screening test indicates an infection, even if further testing negates the initial false-positive.

LifeSource is a not-for-profit organization that collects more than 175,000 units of blood a year for distribution to 55 regional hospitals and 65 home health care organizations. ■

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REPORT FOR *Illinois Physicians*

CESAREAN SECTION REVIEW
BLUE CROSS BLUE SHIELD OF ILLINOIS

Since the early 1970's, the Cesarean Section Rate (CSR) in the United States has risen from 5% to approximately 25% of all deliveries. In 1980, with the CSR at 15%, sufficient concern existed such that an NIH Consensus Conference was called, which made recommendations as to how the CSR might be lowered. This activity was clearly unsuccessful, and by 1984, Cesarean Section had become, and remains, the most commonly performed operation in the United States, including both sexes.

As part of its ongoing Quality Improvement Program, Blue Cross Blue Shield of Illinois (BCBSI) has been monitoring the status of Cesarean Sections performed on its enrollees in participating network hospitals. For the year 1992, the following rates were observed:

Cesarean Section Rates

All Illinois Hospitals	---	**24.6%**
Teaching Hospitals	---	**23.1%**
Non-Teaching Hospitals	---	**25.4%**

Although not possible to define exactly, estimates are that the optimal CSR is in the range of 10-15%. Several recent studies have described how such rates are achievable through focused interventions [1,2]. For 1992, a number of major hospitals in the metro Chicago area did indeed have rates well below 20% for BCBSI insured patients.

In 1992, through its major lines of Illinois business and networks, BCBSI experienced over $26 million in hospital charges for some 2,977 cesarean sections, 18% of which (533) were identified as having complications. The average length of stay and hospital charges for those cases with complications were 35% greater than for uncomplicated cases. Costs for the average cesarean section delivery were approximately twice those for a vaginal delivery.

Cesarean Section performed for valid indications will often preserve the life and health of both mother and infant. However, it is a major procedure not without hazard and complication, and generates substantial incremental cost. Experts agree that currently prevailing rates are excessive, and efforts to lower CSRs are, therefore, appropriate from both quality and cost perspectives.

During 1993, BCBSI has been in contact with many Illinois hospitals regarding their CSRs. Throughout this process, much information has been gathered about the types of activities that have been successful in lowering CSRs, and how these approaches have been implemented. In the future, BCBSI will be sharing these "best practice strategies" with all participating network hospitals, with the goal of our working together to bring about an improvement in the statewide CSR. This information will appear in a future "**Blue Sheet**", as well as being sent directly to the hospitals and to selected physicians in the various BCBSI networks.

1 Meyers SA, Gleicher N: NEJM 319:1511-1516 (1988)
2 Lopez-Zeno JA et. al.,: NEJM 326:450-454 (1992)

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EDITORIAL

Promoting greater patient responsibility

A shocking story was published recently. It wasn't in a supermarket tabloid, and it had nothing to do with aliens. The story, printed in a journal of the American Heart Association, said that American teen-agers show evidence of heart disease, which often rapidly worsens by the time they reach their 30s.

The basis for the story was a major study in which physicians performed autopsies on 1,532 young people. They found that all the teens had signs of fatty deposits in their aortas, and half already had buildup in the smaller arteries. Physicians involved in the study, as well as those unconnected with it, concurred that the findings underscore the need for more aggressive early prevention of heart disease, primarily through healthier diets.

President Clinton's health system reform proposal has caused all of us to think about what's right and what's wrong with the current system. One thing that's right is that we now know about preventive measures that can extend lives and expand the quality of those lives. Regular vigorous exercise reduces the risk of stroke and adult-onset diabetes, according to a recent story in *JAMA*. Vitamins E and C and beta carotene may prevent heart disease. Every cigarette smoked takes seven minutes of a smoker's life, adding up to 5 million years of potential life that Americans lose to cigarettes each year, according to the CDC.

Our patients know what to do – eat a low-fat diet, exercise regularly, limit drinking, stop smoking, minimize stress, maintain a healthy weight, have regular checkups, and get mammograms and prostate tests. Yet it's easier to postpone a healthy lifestyle and expect the doctor to fix it when something breaks – and fix it fast and at little or no cost to patients. This need for greater patient responsibility is one thing that's wrong with the system today, and it will affect the success rate of any reform proposal.

There's a price tag on the sophisticated tests and procedures patients want, but they might never be needed if we all committed to maintaining our health as much as we do our cars and homes. Prevention is a painless way to reduce burgeoning health care costs.

Of course, physicians share in this responsibility by talking to our patients, listening to them and identifying problems early-on, when treatment is less costly. But, ultimately, responsibility for reforming the system lies with each one of us.

PRESIDENT'S LETTER

The benefits of unity

By Arthur R. Traugott, MD



As physicians, we work individually with our patients, but the reform effort needs to be managed by a larger force.

In the midst of the current health care system debate, it is especially critical that physicians stand together. As physicians, we work individually with our patients, but the reform effort needs to be managed by a larger force.

This isn't the time to become divided and risk failing to conquer. We must continue to stand united and know that our voices and our patients' voices will be heard.

Illinois is a unified membership state, which means physicians, students and residents join all three levels of organized medicine – county, ISMS and AMA. From time to time, there are discussions about whether it is necessary to remain unified. For organized medicine to be truly effective, membership must be strong at all three levels. Each serves a distinct purpose, provides distinct benefits and complements the other levels. Strength builds on strength. We cannot have any weak links.

At the national level, unification provides Illinois physicians with a 10-percent discount on their AMA membership dues. This has also given our state two extra delegates in the AMA House. As a result, Illinois has one of the strongest AMA delegations. The AMA also benefits physicians by representing the profession before Congress, the federal judiciary and national regulatory agencies.

At the state level, ISMS provides state legislative advocacy for members and their patients. During the most recent legislative session, that advocacy included efforts to cap noneconomic damages in civil cases, including malpractice suits. This key element of tort reform remains a priority for ISMS in the health care reform debate.

The Clinton proposal, and probably any plan eventually approved by Congress, may allow some flexibility in implementing health system reforms at the state level. Consequently, federal and state legislative advocacy is crucial to put in place a plan that maintains the delivery of high-quality health care for our patients.

ISMS supports physicians and patients by working with government agencies that administer programs affecting health care. This helps ensure that members' concerns are considered before programs are implemented.

In 1976, ISMS created the Illinois State Medical Inter-Insurance Exchange to provide liability protection for its members. The Exchange was founded in response to the decreasing availability of medical professional liability insurance in Illinois. The opportunity to obtain malpractice insurance through a physician-owned insurer is a primary benefit of ISMS membership.

County medical societies are equipped to deal with local issues including local government, interprofessional relationships, indigent care, CME and county agencies. Each county society has an opportunity to grow stronger by recruiting as many potential members as possible for all three levels. This keeps all three organizations strong, and associations must be strong in numbers to be truly effective.

If you have been dissatisfied with a policy or decision at any level, you have the opportunity to change it through your participation and membership. Your suggestions will be taken seriously. The key is active participation, not passivity.

Can you really do better representing yourself? If you had to obtain the benefits and services of all three organizations on your own, the cost would be much greater than the cost of dues.

All levels of organized medicine – your county and state societies and the AMA – are working to reduce your hassles so that you can focus on practicing medicine. That's why you need an organization at each level to represent you. We need all three to maintain our professional well-being and promote professional ethics.

We need every member to renew in 1994. Let's keep our unity as we join the reform debate. We cannot do it alone. Let's stand together and be the strongest advocates for our patients and our profession.



"I warned you not to laugh at me, Dr. Treemont."

WATCH FOR THESE EVENTS

- The Illinois Society of Anesthesiologists' Fall Meeting is scheduled for Nov. 6-7 at the Oak Brook Hills Hotel and Resort in Oak Brook. For information, contact ISA at (312) 263-7150.

- The Illinois Society of Pathologists' Fall Meeting will be held Nov. 12-13 at the Clarion Inn Hotel in Rosemont. For registration information, contact ISP at (312) 263-7150.

- The Metropolitan Chicago Chapter of the American College of Surgeons is holding its Winter Meeting Dec. 4 at the American College of Surgeons headquarters in Chicago. For more information, contact the chapter at (312) 782-1654 or (800) 782-ISMS.

- The AMA's Physicians Health Foundation announces a "call for papers" for the 1994 International Conference on Physician Health. Scheduled for Sept. 16-20, 1994, the program will convene at the Ottawa Westin Hotel in Ottawa, Ontario, Canada. Abstracts will be accepted on topics related to physician health. Entries must be submitted by Feb. 1, 1994, to Elaine M. Tejcek, Physicians Health Foundation, AMA, 515 N. State St., Chicago, IL 60610.



Michael Candee

ISMS' October employee of the month is Hank Hartman, computer services technical trainer. Hartman was honored for keeping employees informed and on the right track during the company's conversion to a new word processing system.

GUEST EDITORIAL

Boosting primary care for women

By Sen. Judy Baar Topinka

As chairman of the Illinois Senate Public Health Committee, I have a special concern when it comes to the quality of health care in Illinois as well as elsewhere in the nation.

This concern led me to clip an article that ran in July in the *Chicago Sun-Times* reporting on a Seattle study about the lack of uniform guidelines in women's medical checkups.

Given the premise that medicine is not an exact science, there is no way to mandate an absolute, uniform set of examinations for all women or all men or all children for that matter. Physicians must be allowed to apply their skills and judgment to serve their individual patients. However, that Seattle study pointed to a number of inconsistencies that can hardly be written off as simple judgment calls.

To begin the study, researchers hired a group of actresses to portray 55-year-old smokers with a family history of breast cancer. They were sent to 57 physicians in the Seattle area. Even though the patient profiles were identical, some doctors spent as little as five minutes with each patient, while others devoted up to an hour. Charges ranged from $24 to $108. The "patients" told the doctors that their mothers had had breast cancer, but many were not given breast examinations.

The U.S. Preventive Task Force, a governmental body, and the National Cancer Institute have outlined a number of uniform tests to be conducted for women in their 50s. I presume that most conscientious physicians are aware of and follow the guidelines, which include monitoring blood pressure, heartbeat and weight; performing oral, neck and breast exams; and conducting mammograms and stool screenings. Physicians should also counsel their female patients about proper nutrition, such as increasing dietary fiber and decreasing dietary fat.

The Seattle study reported high marks for physicians in measuring patients' blood pressure. There they scored 98 percent. Percentages fell, however, when it came to nutrition. After all the women reported that they ate at fast-food restaurants three times a week, only 16 percent were cautioned to decrease dietary fat. Sixty-one percent of the physicians conducted oral exams; 70 percent ordered stool testing; 73 percent told their patient to stop smoking; and 90 percent recommended mammograms. Although the 90-percent figure for mammograms is good, according to a private physician speaking for the American Academy of Family Physicians, it should have been 100 percent.

This study represents Seattle at a given time, under given circumstances. But this is Illinois. I wonder how our physicians stack up.

As most practicing physicians know, women are no longer passive patients. They have become savvy consumers and, in some cases, downright militant. Women are looking at funding statistics and finding that research dollars are seldom being spent on women's diseases to the same extent they are for diseases that primarily affect men. Data gathered from studies on male patients are too often simply extrapolated to apply to women. Much of that is changing, but we are still told that 182,000 new breast cancer cases are diagnosed each year and that 46,000 American women will die of that disease annually. Nobody knows its cause.

I'm carefully watching a plan that is being developed in Illinois as a cooperative effort between the Illinois Department of Public Health and the U.S. Centers for Disease Control and Prevention. The goal of this project is increasing screening and early detection of breast and cervical cancer. Through professional and public education, women will be urged to take advantage of the many screening tests available and taught about the life-saving value of these procedures. Federal funding will be sought to ensure this testing can be extended to women at all socioeconomic levels, regardless of whether they have health care coverage. The priority group will be women age 50 and older.

I hope that by studying the success of this plan, important preventive data can be gathered and that a better, more uniform set of procedures can be provided to our practicing physicians.

My understanding is that low-income patients will be served through existing delivery systems here in Illinois through contracts with the Illinois Department of Public Health. The screening services would include breast examinations, screening and diagnostic mammograms, pelvic examinations, Pap smears, colposcopy, and follow-up care.

Any long-term health care planning is hampered now as we await the outcome of the debate and implementation of the president's health care plan. One would hope that his final plan will stress prevention and early detection – which is exactly what we're talking about here. Preventive medicine has, over the years, often been given more lip service than practice. I commend our Department of Public Health and the CDC for their efforts. I also commend the practicing physicians here in Illinois and the members of the Illinois State Medical Society, who understand the importance of preventive medicine and routinely urge their patients to take advantage of it.



Sen. Judy Baar Topinka *is a Republican state senator from North Riverside.*

Illinois Medicine *is looking for physician-written guest editorials on health care issues. If you have an idea you think might interest your colleagues, contact* Illinois Medicine *at (312) 782-1654, ext. 1261, or (800) 782-ISMS.*

Do no harm

(Continued from page 1)

Physicians have long advocated stressing preventive care to address problems before they become serious, Dr. Traugott said. "But while physicians endorse universal access, particularly to primary care services, we must also be realistic about how much this expanded coverage will cost. Americans typically want the best and most technologically advanced care they can get. And they want it fast. To date, the president has failed to mention whether educational efforts will be built into the system to make patients aware of the ramifications of overutilization. Without underlying patient responsibility for making wise health care decisions, the system could be dangerously underfunded. We can't afford to risk the current high-quality care most citizens are accustomed to receiving."

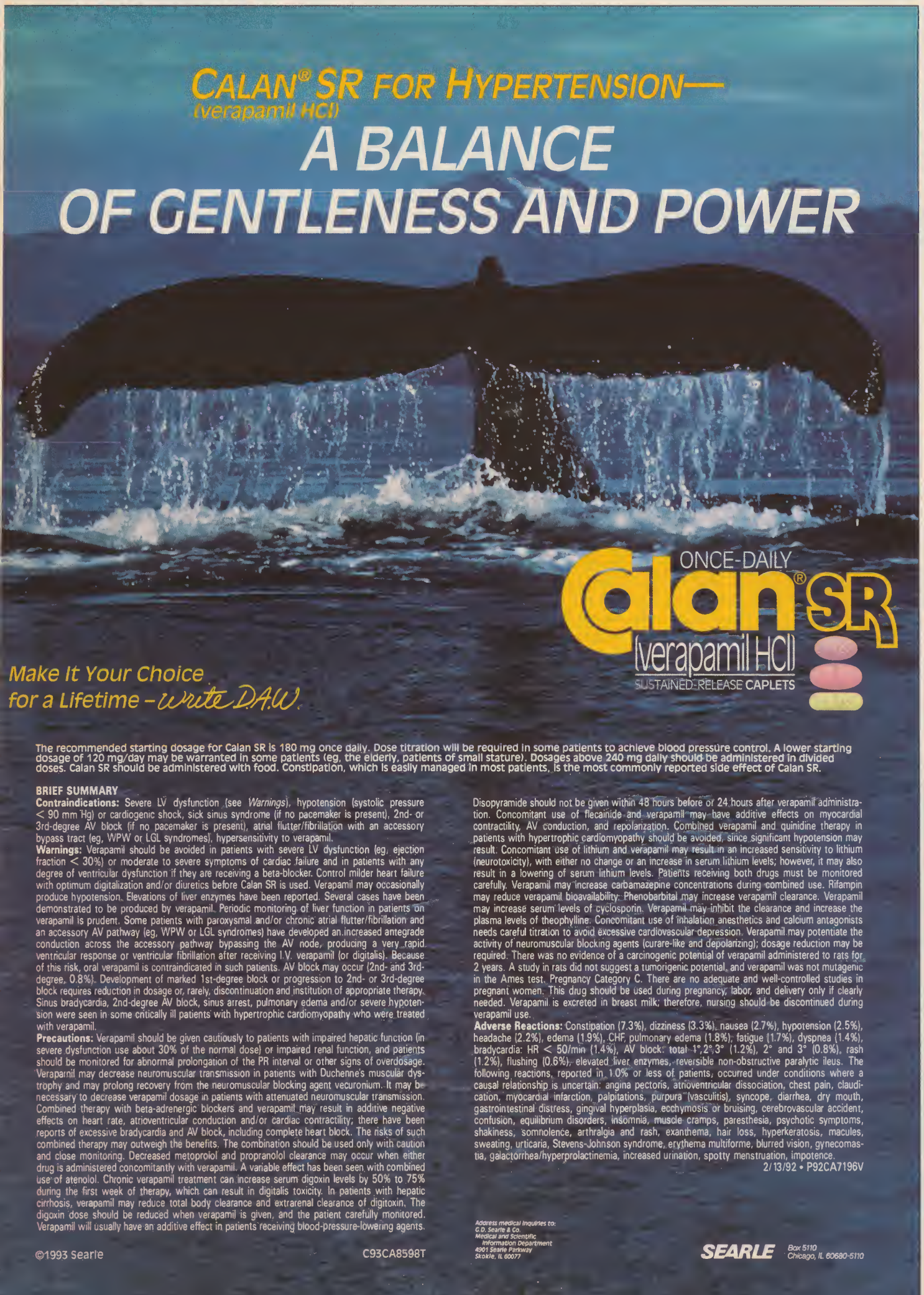
To that end, Dr. Traugott said any reform proposal must assure adequate funding or include a plan for rationing care. Although ISMS supports sin taxes on tobacco products to help fund health care, the Society is concerned that this revenue, coupled with the president's proposed savings through cuts in Medicare and Medicaid and administrative costs, is insufficient to pay for everything he promises. "We also have to be careful not to let financing become the sole driving force behind reform. It's critical that patient care remain the focus of the debate," Dr. Traugott said.

If the administration is serious about containing costs while maintaining quality care, Dr. Traugott said the legal reforms in the proposal must be broadened to include caps on noneconomic damages in malpractice cases. "Without capping the noneconomic portions of awards, health care costs will continue to climb. Too many physicians are forced to practice defensive medicine, because they fear being sued. Caps would restore stability to the legal system and ensure that patients who are truly injured through malpractice are fairly compensated."

ISMS is also concerned that some aspects of the Clinton plan call for unprecedented intrusion into the physician-patient relationship, Dr. Traugott said. Adding more layers of bureaucracy in the name of quality assurance will not improve patient care, he noted. "Doctors are also wary about the composition of the National Health Board, the National Quality Management Program's council and Health Alliances. The president's intent appears to be that no physicians will serve as decision-makers in any of these bodies. It's difficult for us to comprehend how a health care system can provide top-notch services without input from providers on the front lines."

Similarly, the government must act to remove antitrust restrictions for physicians, Dr. Traugott said. Without antitrust protections, physicians are unable to enter fair service agreements with other providers and negotiate freely with third-party payers. As the laws currently stand, organized medicine is severely limited in its ability to police the profession and monitor fees, he said.

"As physicians, we are ethically bound to uphold the Hippocratic oath of doing no harm. It's also our duty to provide our patients with the best quality health care we can," Dr. Traugott said. "That's why we will actively lobby Congress to ensure that changes to the delivery system help, rather than harm, our patients." ■



State honors water systems with required fluoride levels

[SPRINGFIELD] The Illinois Environmental Protection Agency and the Illinois Department of Public Health recognized administrators of 92 local water systems for maintaining required fluoride levels in their drinking water during the past year. Communities in 71 Illinois counties were honored.

Sixteen of the systems – including the Evanston Water Department, Northern Illinois Water Corp. in Champaign and the Rockford Water Department – have earned the commendation for the last five years. In addition, 77 communities received honorable mentions for reaching fluoride standards in 11 of 12 months during 1992.

The IEPA requires communities to send monthly water samples to certified labs for fluoride testing. The agency also tests for a variety of other water problems, said Joan Muraro, an IEPA spokesperson. Bacteria levels must be checked at least monthly, and sometimes once every two weeks. If high bacteria levels are found, the water must be tested daily until levels are consistently acceptable, Muraro said.

To receive commendations, communities must maintain the required fluoride level of 0.9 to 1.2 mg/L for one year, said Mike Crumly, an IEPA environmental specialist. However, fluoride levels often fluctuate, he said. "The standard is difficult to meet. A lot of supplies fall just under or over the satisfactory mark."

"When the fluoride levels in public water supplies meet state standards, the citizens of these communities benefit through improved oral health," said IDPH Director John R. Lumpkin, MD.

There are 1,931 public water supplies in Illinois. ■

In the next issue . . . Watch for a comparison of malpractice climates in the United States, Canada and England

ISMIE Update

Why patients sue

The good news about malpractice litigation is that it is often avoidable.
By Kathleen Furore

The reasons for malpractice lawsuits are as varied as the outcomes that cause patients and their families to seek compensation in court. But whatever the stated reason a lawsuit was filed – criticism of prior care by a subsequent treating physician, high current and potential medical bills resulting from the injury, or a personality conflict between the patient and the physician – poor communication during treatment is a factor that likely prompted the patient to sue.

"The most common reason patients sue is that there is a misunderstanding about expected results," said Robert Baron, a malpractice defense attorney with Rooks, Pitts & Poust in Joliet. "Patients didn't completely understand the risks or benefits [of treatment]. Their expectations exceeded reality, and they think the doctor must have done something wrong, so they seek a lawyer. In every case, there is the underlying assumption that the result was not as expected. And if it truly should have been expected, there was a lack of communication by the physician."

An article in the *Physician's Legal Monitor* cites a Texas Medical Association survey of 263 patient families who collected malpractice damage awards or settlements. The author notes, "More than half of those questioned reported they were so perturbed by the doctor's attitude that they wanted to sue before the alleged malpractice occurred."

The article also cites a Vanderbilt University study showing that 24 percent of 127 families surveyed "filed a claim when they realized the physician did not honestly report to them the circumstances underlying the injury. These families thought the physicians either allowed them to believe something the physician knew to be inaccurate or actively misled them."

Of course, communicating with patients is important. But developing a rapport with patients – whose expectations of physicians are higher than in the past – is becoming more difficult. "The answer is good communication, but getting there is a devilish problem," said Baron. "People's expectations are so high, and people [in general] are so annoyed with doctors."

Inappropiate communication between physician and patient can also lead to lawsuits. For the past several years, the Exchange has tracked the reasons plaintiffs filed malpractice lawsuits against physicians. In many cases, it is impossible to determine the reason. However, in those instances in which the cause could be identified, an underlying reason often cited

(Continued on page 8)

UNDERLYING REASONS FOR MALPRACTICE SUITS

1. Physician was named as a peripheral defendant
2. Subsequent treating physician allegedly criticized prior care
3. Potential for large future medical bills
4. Personality conflict between physician and patient
5. Large current medical bills (collection has not yet been initiated)
6. Plaintiff or patient feels access to the physician was restricted or vital information was withheld
7. Family member or friend is an attorney
8. Family member or friend is in the medical field
9. Personality conflict between physician's office workers and patient

Source: Illinois State Medical Inter-Insurance Exchange

MALPRACTICE ROUNDUP

Reducing medication error lawsuits

Physicians should obtain and document informed consent from patients when they prescribe drugs with potentially significant complications or side effects, according to the Physician Insurers Association of America. As reported in *Chicago Medicine*, a PIAA study revealed that medication errors are the second most frequent and the second most expensive cause for claims against physicians. These claims create a substantial loss for malpractice insurance carriers and their insured physicians, the PIAA study said.

The study identified several steps to improve patient care and reduce patient injury caused by medication errors. These include charting on "flow sheets" all prescriptions and refills on medication; obtaining, documenting and regularly updating patients' medication histories; educating patients about their medications; and closely monitoring patients' drug usage and possible side effects, particularly with controlled substances. ■

Hiring nonphysician staff

Because physicians are legally responsible for their employees' actions, proper hiring and orientation procedures for nonphysician staff are critical risk management practices, according to Norcal Mutual Insurance Co.

In its publication *Mutual News*, Norcal encourages physicians to take active roles in the employee selection process. Physician participation helps appropriately match candidates' qualifications with positions on the health care team. Prospective employees' licensing, certifications, education and prior employment history should be verified before offers are made, Norcal advised. This will help avoid legal issues related to performance problems and scope of practice. Norcal also suggested that interviewers assess candidates' ability to interact with patients, since poor communication can lead to lawsuits.

Once employees are hired, physicians should give them a written job description and a policy and procedures manual to provide structure and guidelines for the job. All employees should also receive an orientation specific to their position. ■

Fund proposed for breast implant claims

Women with breast implants who develop any of eight diseases could collect from $200,000 to $2 million if a settlement proposal announced Sept. 9 by Dow Corning Corp. is approved. As reported in the *Chicago Tribune*, lawyers representing defendants and plaintiffs in a class action lawsuit have suggested a $4.75 billion fund to compensate women with silicone gel breast implants.

The proposal was made by implant makers Dow Corning, Bristol-Myers Squibb Co. and Baxter Healthcare Corp. The fund would be built from contributions by corporations that made implants, companies that supplied raw materials for the implants, insurance companies, doctors and other health care providers, Dow Corning said.

The fund would allow smaller awards for women seeking removal of implants or medical care. Women with no diseases attributable to implants could seek compensation for mental anguish, according to the settlement proposal. The companies would also waive the statute of limitations for filing liability claims so that women could come forward at any time over the next 30 years and claim injuries, Dow Corning said.

The proposal must still be approved by the boards of directors of implant manufacturers, insurance companies, physicians, a committee of plaintiffs' lawyers and the chief judge overseeing the class action suit, according to Dow Corning. Physicians reviewing the proposal have expressed concerns about whether breast implant suits are a malpractice issue or a product liability issue, said Barbara Carmichael, Dow Corning spokesperson. ■

Why patients sue

(Continued from page 7)

was that the subsequent treating physician allegedly criticized prior care. (See list on page 7.)

"This practice is a very real threat to physicians and contributes to the incidence of malpractice litigation," said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. "If a physician feels compelled to make any gratuitous comments or criticize a prior physician's care, the subsequent treating physician should at least gather the facts first. Experienced physicians do not accept a patient's version of what happened without the previous medical records in hand."

In addition to having all the facts before commenting on quality of care, physicians can take the following steps to improve communication with patients:

• Engage patients in conversation during office visits. "Get patients talking to you in a way that breaks down communication barriers," advised Kevin Glenn, a medical malpractice attorney and a senior partner at Chicago's Bresler, Harvick & Glenn. "You can't just say, 'How are you feeling?' because you'll hear, 'Fine.' Talk to them in a way that gets them to give you more detailed and accurate information that will enable you to treat them better."

Glenn noted that such rapport increases patients' confidence in physicians and makes them feel better about the care they're receiving.

> *Experienced physicians do not accept a patient's version of what happened without the previous medical records in hand.*

• Ask patients to repeat information and instructions you've given them. "It's like going to school. You have to test the students, and the test proves what kind of teacher you are," said Baron, describing a taped scenario used during risk management presentations. "We show a physician talking to a woman with breast cancer in very technical terms about her disease and treatment options. The doctor asks the patient to repeat what she has been told to assure that she understands. You would be surprised at how little the patient understands."

• Insist on talking to patients about everything – including potential problems. "People don't want to hear distressing things," said Glenn, adding that it is nevertheless important to tell patients about the potential risks as well as benefits. "You've got to give enough information for patients and their families to make reasoned decisions. Even if there's really no choice – it's either 'follow this treatment or die' – the patient and family members want to know why that particular treatment is necessary and if it's the only thing available."

Baron, too, stressed the importance of fully disclosing potential benefits and risks, and advised such disclosure even when patients say they don't need to hear a complete explanation. "I'm convinced that if patients knew the risks of treatment and were given correct assessments of probable outcomes, there would be less patient dissatisfaction and less malpractice litigation," he added.

• Tell patients if you are referring them to another physician or are bringing in a consulting physician, and avoid breaking the communication link you've already established with your patient. Glenn noted that communication becomes even more difficult when another party is helping manage a patient's care and treatment. "The further down the line you go, the more difficult communication becomes," said Glenn, referring to the specialization so prevalent today. "I, as a patient, would expect the referring doctor to tell me he or she is bringing in a consultant.

"If you have good communication skills, you'll invariably have good written records, which are always the best defense," concluded Glenn. ■

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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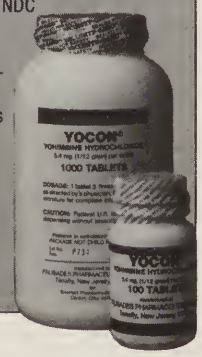
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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HEALTH CARE ABROAD

Practicing medicine a world away

Through a sister city exchange program, a Russian physician enlightens Illinois doctors about her country's medical dilemma.

BY ANNA BROWN

Helen Vladimirova, MD, practices medicine in a city in which 80 percent of the local budget is earmarked for health care. There is no malpractice litigation. And her medical training was free.

But in Vladimir, Russia, antibiotics are rarely available. Infections in hospitals are rampant. And much of the medical equipment must be obtained through charitable donations from countries like the United States.

Nutrition is also a major health concern in Russia. In addition, Dr. Vladimirova said she has seen increasing numbers of patients turning to alcohol and tobacco in recent years. "Our people smoke a lot. They drink a lot. And when people drink, they don't [care about] anything. My colleagues also drink and smoke a lot, even in the hospitals."

On Sept. 11, Dr. Vladimirova, an orthopedic surgeon and burn trauma specialist at the Red Cross Hospital in Vladimir, arrived in Bloomington as part of a medical exchange through the Bloomington/Normal Sister Cities program. She came to the United States to serve as a translator and attendant for her hospital's director of nursing, who was to undergo hip replacement surgery in Bloomington. Dr. Vladimirova is the first physician from Vladimir to visit the city. Richard Trefzger, MD, a Bloomington surgeon, originally suggested that the sister cities program begin medical exchanges with the Russian city.



Marc Featherly

Dr. Vladimirova

Dr. Trefzger met Dr. Vladimirova during his visit to Vladimir with two other Bloomington physicians this year. He spent much of his time at the Red Cross Hospital where she works. "We tried to get to know people, find out what the system was like, how they did things, how they solved problems we both share. We wanted to meet our colleagues and become friends," Dr. Trefzger said.

That friendship led to Dr. Vladimirova's visit to Bloomington. During her six-week stay, she visited hospitals and spoke to Bloomington citizens about health care in Vladimir. Her first presentation was to the McLean County Medical Society on Sept. 14, three days after arriving in the United States.

(Continued on page 10)

Health care abroad

(Continued from page 9)

"My first impression is that everything is different here," Dr. Vladimirova said. "When I think of our crazy situation, I think of the intelligent people here and their polite manners. Unfortunately, physicians in Russia are not polite. Not to each other, nor to their patients.

"Unfortunately, we have a myth about Americans," she continued. "Many of our people think that Americans drink a lot, smoke a lot, are very sexy, very aggressive. They think they have hats and shoes like cowboys. They can't imagine that Americans are a very quiet, intelligent people." Dr. Vladimirova said the myth was created by American television programs, advertisements and films that the Russian government translates. She blames the government for failing to provide more positive and educational programming.

In her speech to the medical society, Dr. Vladimirova described her experience working under the Soviet government. "Our totalitarian regime pushed medicine to the level of militarism. I felt like a soldier." The government dictated that no matter what problems the health care system incurred, it would still be considered the best, she said. "Self-confidence in the system led to its deterioration."

Russian health care has not improved, however, since the fall of the Communist government, Dr. Vladimirova said. The "criminal" state of the country's health care system has led to "total traumatization" of patients, she said.



Courtesy of Richard Trefzger, MD

The chief of ophthalmology at Red Cross Hospital in Vladimir, Russia, demonstrates a Cyrillic alphabet eye chart.

Dr. Vladimirova told physicians of her fears about the future of the medical profession in Russia. "Our most talented youth have less desire to go into medicine."

Under Soviet power, students attended medical institutions free, she explained. Since 1992, however, students have had to pay for training. According to Dr. Vladimirova, the students now attending medical institutes in Russia are rich, but not necessarily talented.

Students enter the medical institutes at age 17. They spend five years studying general therapy, and in the sixth year, they specialize, she said. Because most students want to specialize in surgery, competitions are held for surgery specialty slots within the institutes.

Dr. Vladimirova said she knew she wanted to be a surgeon when she was in the ninth grade. Although the institutes generally accept mostly male students, it is "not very difficult" for women to enter medical training, she said. However, most women study only general therapy. Dr. Vladimirova is the only physician in Vladimir trained in orthopedic surgery.

"We are trained in self-sacrifice," she said. "My first orthopedics professor told us that to save someone's life, you should [be willing to] leave your own child. I disagree."

THE SISTER CITIES relationship between Vladimir and Bloomington/Normal was formalized in February 1989. Since then, many cultural, athletic and business exchanges have occurred. Dr. Trefzger said the cities were a logical pair for the sister cities program because they support two universities and an automobile manufacturing plant, among other similarities.

> *Unfortunately, we have a myth about Americans. Many of our people think that Americans drink a lot, smoke a lot, are very sexy, very aggressive.*

However, the health care structure in Vladimir is markedly different from that of Bloomington/Normal. Dr. Vladimirova explained that the city has nine specialty hospitals. The Red Cross Hospital specializes in trauma, surgery and burns. In addition to the hospitals, there are satellite clinics, or "policlinics," where people go when they are ill.

Citizens are assigned to a certain policlinic at birth, said Jana Edge, a Bloomington nurse and co-chairman of the Bloomington/Normal Sister Cities medical delegation. Policlinic physicians refer patients to local hospitals when necessary, Edge explained. Once they are hospitalized, patients see only hospital physicians. If they need further treatment after they are released, they must return to the policlinic and the staff doctor there. This leads to longer hospital stays, Edge said. "The average hospital stay is 15 days. It's not unusual for someone to be in the hospital for two to three months."

"We don't have good specialists in policlinics," Dr. Vladimirova said. "It's better for my patients to stay longer in the hospital than for me to push them into the policlinic. I must be sure that all will be OK with my patient and that I can say goodbye with a light heart."

The main goals of Russian physicians involve bolstering medical supplies, Dr. Vladimirova said. "To have enough drugs, enough equipment. In general, every hospital has financial problems."

Dr. Trefzger and other medical exchange members have attempted to ease that burden by collecting and sending medical supplies and equipment to Vladimir. In 1992, the sister cities program sent equipment valued at $400,000 to Vladimir, he said. "This year, we took $1.2 million worth of equipment – over 3½ semitrailer loads."

Not only are the hospitals underfunded, but physicians also receive low salaries, Dr. Vladimirova said. The base salary for physicians is 46,000 rubles, or about $100, per month. Physicians may supplement their income by working extra shifts. "In general, when I'm on duty, I stay at the hospital a day and a half," she said.

"Sometimes people ask me why I work so hard," Dr. Vladimirova added. "Our unit is very hard. Burn trauma is horrible. But I quite understand that my work is very hard. It's dirty. But I like it. And that's why I work."

Dr. Vladimirova said she hopes the health care situation and the political climate in Russia will improve. "But now every normal person doesn't even see a light of hope for the future. It's very bad, because I think about my daughter, about other children. About their future. A future without any hope, without any happiness."

But she said she doesn't consider living somewhere else. "I don't think about it. I want to have my country more quiet. And more polite." ■



Courtesy of Richard Trefzger, MD

Bloomington ophthalmologist Catharine J. Crockett, MD (left), shows the Red Cross Hospital ophthalmology chief how to use equipment to examine retinas.

Medical Malpractice
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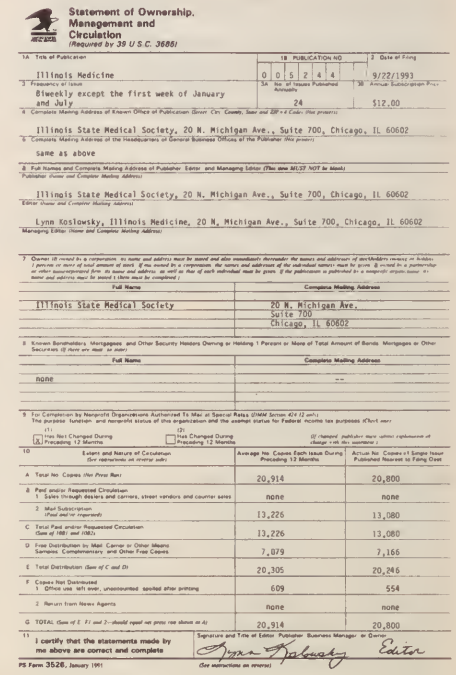
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Breast cancer

(Continued from page 1)

annual mammogram for every woman over 50."

ACS surveys have shown that the No. 1 reason patients fail to receive mammograms is that their physicians did not discuss it with them, Dr. Sener said.

During October, ACS is working with hospitals and clinics throughout Illinois to provide low-cost mammography screenings and breast cancer awareness education programs. In Illinois, women who receive mammograms during October are given pins intended to encourage conversation about the importance of mammography screening. The society is also providing physicians with lists of local mammography facilities accredited by the American College of Radiology.

THE SOCIETY ESTIMATES that 4,821 Illinois women are alive because their breast cancers were detected early. The proportion of Illinois women whose breast cancers are diagnosed in the earliest stages has risen from 2 percent before 1983 to 12 percent in 1991, according to ACS. The survival rate for patients whose breast cancer is detected before a lump can be felt approaches 100 percent.

ACS studies in Illinois of women with breast cancer have shown that mammography detects cancer when it is smaller and cannot be detected by other means, Dr. Sener said. "It's clear to us that aggressive mammography has led to a significant decrease in the size of breast cancer. But we have yet to prove that detection leads to reduction in mortality" for women under 50.

The studies, which were conducted in the late 1980s, were unable to prove a reduction in mortality for women in their 40s because "death curves won't change until the end of the decade," Dr. Sener said. Before mortality rates can begin to be evaluated, there must be patient follow-up for 10 years, he said.

The National Cancer Institute is currently debating the question of whether women age 40 to 49 should receive yearly mammograms, said Dr. Sener, who is a member of the NCI subcommittee on breast cancer detection and treatment. NCI recently proposed new guidelines for breast cancer screening recommending that women in their 40s seek advice about mammography from a health care professional. Recommendations adopted in 1988 advise all women in this age group to receive routine mammograms. The new cancer screening guidelines are based on the results of several randomized clinical trials, Dr. Sener said.

The clinical trials did not show a conclusive reduction in mortality for women in their 40s, Dr. Sener explained. He noted that none of the tests showed reduced mortality seven years after screening. However, after 12 years, the studies showed a 12-percent to 13-percent reduction. "We're not sure if this is clinically significant," he said, but noted that a decreased death rate may not be evident until the 18th year, which the studies have not measured.

The debate over the new guidelines is expected to be resolved in the next few months, Dr. Sener said. "We hope to come to a consensus on whether mammograms reduce mortality in younger women."

Dr. Sener stressed, however, that there is a clear reduction in mortality for women screened annually between the ages of 50 and 70. "Our message to the public and physicians is that we are committed to [the NCI] screening and examination guidelines."

Physicians interested in obtaining ACS breast cancer materials may contact the American Cancer Society, Illinois Division Inc., 77 E. Monroe, 13th Floor, Chicago, IL 60603-9967. ■

Breast cancer awareness quiz

Are the following statements true or false?

1. Most women who develop breast cancer can be saved if their cancers are detected and treated early.
2. If a woman examines her breasts every month, she does not need to have routine mammograms or clinical exams.
3. Older women are more likely to get breast cancer than younger women.
4. The U.S. breast cancer death rate has skyrocketed.
5. Women who are in good health can still get breast cancer.
6. Cumulative exposure to radiation from screening mammograms causes breast cancer.
7. It's very difficult for a woman to determine whether she is getting a mammogram that is safe and of high quality.
8. Obesity and dietary fat have been associated with risk for breast cancer.
9. Illinois private insurance, Illinois Medicaid and U.S. Medicare now cover screening mammograms.
10. Mammograms can detect breast cancer before any symptoms are noticed or a lump can be felt.

1. True; 2. False; 3. True; 4. False; 5. True; 6. False; 7. False; 8. True; 9. True; 10. True

Source: The American Cancer Society, Illinois Division Inc.



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Lead poisoning

(Continued from page 1)

In addition, the CDC lowered the level at which lead is considered dangerous from 25 micrograms per deciliter of blood to 10 micrograms. When this year's testing is completed, IDPH expects to have identified elevated lead levels in 170,000 of Illinois' 1 million children under age 7.

Parents should be aware of lead sources in their home, said IDPH. Children can be exposed to lead through dust, dirt and drinking water. Toys and houses painted before 1975 – the last year lead-based paint was used – are also a hazard, warned IDPH. Exposure also often occurs during home-remodeling projects. Children may eat paint flakes or inhale or lick lead dust. The department recommends that before remodeling a home built before 1975, parents seek a professional consultation from a contractor or move the family to another location until the renovation has been completed.

"Children are not little adults," said Dr. Hatch. "They have a tendency to eat things that shouldn't be eaten. They are more likely to be in contact with lead that could get into their systems. The lead stores in their bones, and as their bones grow, the lead is then rereleased into their systems."

Conducted at local health departments and physicians' offices, the lead screening usually consists of a simple finger-prick test, according to IDPH. If the test results indicate a level of 15 micrograms or higher – the levels at which physicians diagnose lead poisoning – the child is called back for a confirmation test and follow-up, said an IDPH spokesperson.

When lead poisoning is confirmed, efforts should be made to reduce the child's lead exposure, advised IDPH. Treatment for low-level poisoning consists of eating foods high in calcium – such as meat, eggs, fruits and green vegetables. A diet high in fat or oil tends to retain lead in the child's system, according to IDPH.

When levels are between 10 and 19 micrograms, IDPH recommends educating parents on how to reduce lead, especially lead dust, in their homes. For levels of 20 micrograms, physicians may request a home environmental visit to determine the source of the lead. Levels of 25 micrograms or more require outpatient medical treatment to remove the lead from the child's body. At levels of 45 micrograms or more, the CDC requires an environmental visit. And if the lead level reaches 70, the child is hospitalized.

Although the effects of lower lead levels may not be evident in individual children, definite trends have been identified when children are studied collectively, Dr. Hatch said. "Even minimal levels of lead exposure can lead to irritability, loss of appetite and inability to sleep, and can have effects on cognitive ability. It's important to remember that there is no 'normal' lead level. No level of lead has proved beneficial." ■

New federal law affects tax status of dues used for lobbying

[WASHINGTON] Congress has passed and President Clinton has signed into law the Revenue Reconciliation Act of 1993, which does not allow expenses used for lobbying on federal and state legislation and federal officials to be tax deductible as a business expense. Therefore, the portion of ISMS and AMA dues used for those purposes will not be tax deductible after Jan. 1, 1994. This does not affect political action committee contributions, since they are currently ineligible for favorable tax treatment.

ISMS is notifying members of this new law with an insert provided with dues statements. In January 1994, when more accurate budget and dues income information is available, members will be notified of the nondeductible portion of dues.

Members should consult their tax adviser for application to their individual circumstances. ■

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Illinois Medicine

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Revealing the faces of domestic abuse

PAGE 12



Matt Ferguson

FIRST LADY HILLARY RODHAM CLINTON meets with Chicagoans at the James R. Thompson Center Oct. 21 to drum up support for the president's reform proposal. The administration introduced its reform legislation – the Health Security Act of 1993 – in Congress Oct. 27.

President Clinton's health system reform bill was sent to Congress as Illinois Medicine *went to press. Watch for future coverage of legislative developments.*

ISMS takes action on reform

HEALTH SYSTEM REFORM: Through ISMS programs, mailings and meetings, physicians support maintaining quality patient care. By Anna Brown

[CHICAGO] Following the national presentation of President Clinton's health system reform proposal, Illinois physicians took quick action to help ensure that patient care would not be compromised under future health care legislation. Sixteen ISMS and Chicago Medical Society leaders met with the Illinois congressional delegation in Washington Sept. 29-30 to discuss the need for elimination of excessive bureaucracy, stronger medical malpractice reforms, and antitrust relief for physicians.



"ISMS laid a solid foundation within the congressional offices for future discussions on health system reform," said ISMS President Arthur R. Traugott, MD. "We will continue to monitor and participate in the debate as it unfolds, and now that legislation has been introduced, we will be prepared to work at protecting the rights of physicians and patients."

(Continued on page 19)

Reform presents challenges for CME

CHANGE: New demands will alter continuing medical education. By Janice Rosenberg

[CHICAGO] As health system reform proceeds, continuing medical education will play a considerable role in helping physicians adjust to the inevitable changes in the practice of medicine. Reform will influence the number of CME programs available, as well as the topics presented and the style of presentation, according to K.M. Tan, MD, vice chairman of the Accreditation Council on Continuing Medical Education Committee on Review and Recognition and assistant physician-in-chief at Kaiser Permanente Medical Center in Richmond, Calif.

Physicians will also attend televised lectures in hospital conference rooms and learn independently through interactive programs displayed on personal computers, Dr. Tan told attendees at an ISMS-sponsored interstate CME accreditation meeting Oct. 15 in Rosemont. He said courses will focus on managed care, ways to increase the number of generalist physicians and the most cost-effective methods of providing patient care.

Under health system reform, CME will reflect and support the changing nature of the country's medical practices, according to Dr. Tan. One such change is that physicians will probably have less free time for volunteer duties associated with planning, conducting and attending CME courses. "Physicians may no longer have the luxury of attending courses that sound interesting, somewhat esoteric, perhaps tangential to their practices. Focused, individualized, self-directed educational activities that will be relevant to their patients and practice will predominate. [Physicians] will be interested in programs that will cost them nothing, or cost less than they do now, and programs preferably

(Continued on page 14)



Amy Rothblatt

Dr. Tan

INSIDE

Flu shots recommended for elderly, chronically ill

PAGE 4

DEPARTMENTS

News Briefs.....2
Commentary.....6
Letters.....7
ISMIE Update.....9
Classifieds.....16

Illinois physicians debate president's proposal

The new focus on primary care

By Gina Kimmey

Five years into health system reform, at least 50 percent of new physicians will be trained in primary care, according to President Clinton's reform proposal. Shifting the focus from specialized treatment to primary and preventive care puts a spotlight on the family physicians, internists, pediatricians and Ob/Gyns who provide that care every day.

Overall, primary care physicians across the state embrace the idea of universal access, with guaranteed insurability and a focus on prevention. But they are expressing concerns about who will provide that care and what it will cost. Currently, the proposal

(Continued on page 18)

Specialists consider their roles

By Anna Brown

As discussion of President Clinton's health system reform proposal moves from the White House to Congress, physicians statewide are beginning to voice a mixture of guarded optimism and serious concern. Several Illinois specialist physicians praised the president's call for universal access to care. However, many have grave misgivings about the practical consequences of the plan. They said if the proposal is put into practice, it might create additional unanticipated health care problems, such as government-mandated overreliance on primary care.

"President Clinton has done

(Continued on page 18)

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ISIM named component society of the year

AWARD: The American Society of Internal Medicine recognizes Illinois. By Anna Brown

[WASHINGTON] The American Society of Internal Medicine named the Illinois Society of Internal Medicine 1993 Component Society of the Year during the ASIM annual meeting Oct. 14 in Washington, D.C.

ISIM was recognized for "combined excellence" in membership and recruitment efforts, quality of communication with members and effectiveness of its committees, according to a letter written by ASIM President Richard D. Ruppert, MD. "ISIM has set an excellent example for all state component societies of internal medicine to follow," Dr. Ruppert wrote.

The annual award is presented to the component society that carries out the most comprehensive efforts to further ASIM goals, said Alex Gramling, ASIM spokesperson. This is the first time ASIM has recognized the Illinois society since the award was first presented in 1969.

"We look for excellence across the board, and Illinois certainly demonstrated [excellence] in the past year," Gramling said. Most notable was ISIM's annual job fair, he said. The fair links physicians and residents with recruiters from hospitals, managed care organizations, clinics and group practices. This year, the event also featured educational seminars on issues such as contracting and malpractice. "The job fair has become bigger and better every year," Gramling said. "Given the voluntary nature of the event, Illinois' effort was above and beyond the call of duty."

The award "encompasses programs, seminars and communications skills that ISIM has had for a number of years," said ISIM President Stephen R. Goetter, MD. "We've tried to take the forefront in educational seminars that our members would find helpful."

ISIM also participates in ASIM's key contact program to lobby federal lawmakers on behalf of the society, Gramling said. ISIM was "helpful in galvanizing member support" and "lobbying for changes in President Clinton's Medicare budget," Gramling said. At the state level, ISIM worked closely with ISMS to target legislators as part of its advocacy efforts.

ISIM also increased its membership by more than 20 percent during the past year. The increase is "noteworthy given the economy and the flat membership in organizations around the country," Gramling said. ASIM has seen a "slow but steady growth" in recent years, but a "20-percent jump for any state or national organization is significant," he noted.

Although the component society award is designed as an annual honor, the award is not given if the award committee determines no state merits recognition. "You have to earn it," Gramling said. ■



Linda Henson

ALICE HOUT, of WHOI-TV 19, maneuvers through a doorway during Peoria's recent Wheelchair Scavenger Hunt. Sponsored by the Institute of Physical Medicine and Rehabilitation and the Methodist Medical Center of Illinois, the event showed that under the Americans with Disabilities Act, barriers must be removed from public places and access for the physically challenged must be improved.

Republican Leader Bob Michel announces his retirement

[WASHINGTON] After serving in Congress for 38 years, House Minority Leader Bob Michel (R-Peoria) announced last month that he will not seek re-election.

"Had George Bush won re-election, I would have felt obligated to see his administration through and cap my career with 40 years in the House," Michel said. "I don't have that obligation now. When I complete this term it will be 38 years in the House, eight years as an assistant to my predecessor and over three in the military, which adds up to just under 50 years in public service. That ought to be enough. I think it's a good time to hang it up."

Michel's first Republican leadership position was as chairman of the Republican Congressional Campaign Committee in 1972. He was named Republican whip in 1974 and elected minority leader in 1980. During his tenure, he served on the House Appropriations Committee for 20 years, and is currently an ex-officio member of the House Intelligence Committee. He also served the Republican Party as permanent chairman of the Republican National Convention in 1984, 1988 and 1992.

"In the House, while we're still in the minority, where I've always been, we're pulling together and making the most of our numbers," Michel said. "And even though I believe the prospects are excellent for our winning big in the House next year, I'm not sure it will be enough to make me speaker. Therefore, I believe it appropriate to announce my intention to bow out now, when we're on a high and there's time remaining in this term to help make an orderly transition from my leadership to whomever."

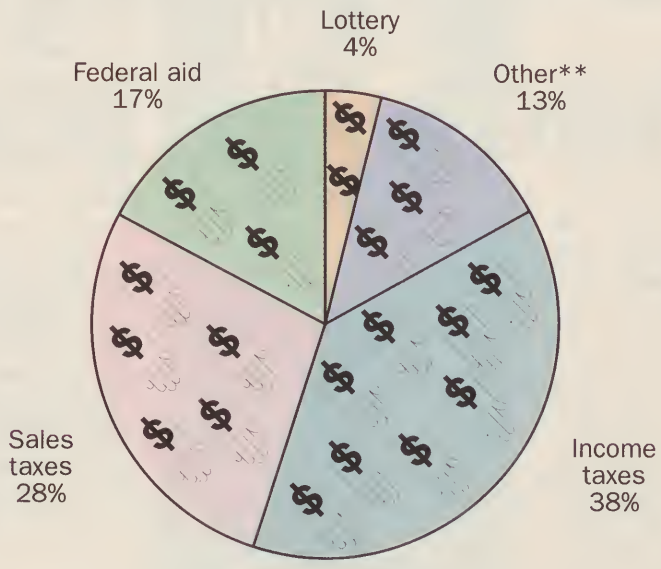
Michel said he will spend the remainder of his congressional career working toward enacting legislation on several issues that require bipartisan cooperation, such as health care reform, NAFTA, and welfare, campaign and congressional reform.

"Yes, politics can be a noble profession," he said. "One of my constant goals in life has always been to prove to my once-doubting parents that it could be so." ■

PHYSICIAN FACTS

The pieces of Illinois' GRF pie

Fiscal '94 General Revenue Funds by source*



*Fiscal '94 General Revenue Fund base is $15.3 billion
**Includes public utility taxes, cigarette taxes, and insurance taxes and fees

Source: Illinois Bureau of the Budget

ISMS sponsors writing award

[CHICAGO] This year's winner of the Illinois Press Association's "Best Coverage of Medicine" contest is reporter John Ambrosia of the *Elmhurst Press*. The ISMS-sponsored award honored Ambrosia's three-part series "The Health Care Dilemma" for its clear and objective reporting on health system reform issues. Awards were presented during the IPA annual convention in October.

The medical writing award is open to all Illinois newspaper reporters who cover health topics. Articles are judged on accuracy, originality, clarity, depth of information presented and overall value in promoting public health and understanding of current medical issues. ■

Edgar kicks off charity drive

[SPRINGFIELD] The State and University Employees Combined Appeal (SECA) – the annual autumn state employee charity drive – is under way, Gov. Jim Edgar announced. Through the SECA campaign, state employees make voluntary contributions by check or payroll deduction to one or more of 10 participating charities. The goal for this year's drive, which ends Nov. 15, is $2.2 million, Edgar said, adding that the charities include various health and human services organizations and programs in Illinois. Last year's campaign raised $2.1 million.

The 1993 charity drive theme is "We Can Make A Difference!" The appeal is co-chaired by Lt. Gov. Bob Kustra and Stephen B. Schnorf, director of the Illinois Department of Central Management Services. The department helps administer the program.

In the past, the employees' "remarkable generosity was consistent with the tradition of kindness and empathy that state and university employees historically have had for those less fortunate," Edgar said. "Illinois' communities and citizens are better off because of the unselfishness of our employees."

Employees may send contributions to a specific charity or to a group of charities, such as the Combined Health Appeal. This group is made up of 19 agencies, including the American Cancer Society, the Crohn's and Colitis Foundation of America, and the Illinois Society for the Prevention of Blindness.

The 10 SECA-member charities are the Illinois Women's Funding Federation, International Service Agencies, Veterans Protective League, Public Interest Fund of Illinois, The United Negro College Fund, Little City Foundation Serving Children and Adults with Mental Retardation, Black United Fund of Illinois Inc., Special Olympics of Illinois, Combined Health Appeal and United Way. ■

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Legislators urge passage of helmet law

MOTORCYCLE INJURIES: Two state lawmakers renew their support for enacting legislation to save lives and avoid further cuts in federal road funds. By Anna Brown

[CHICAGO] State Sen. John Cullerton (D-Chicago) and Rep. Jan Schakowsky (D-Evanston) promised Oct. 22 to reintroduce legislation mandating the use of helmets for motorcyclists and their passengers. Illinois is one of only three states without a mandatory motorcycle helmet law.

If a helmet law is not enacted by Oct. 1, 1994, Illinois will lose additional federal road construction funds, which must be redirected into highway safety programs. The state has already lost $5 million in highway construction funds, because lawmakers failed to pass helmet legislation by Oct. 1 of this year, Cullerton said during a press conference at the Rehabilitation Institute of Chicago.

"The people who say that helmets don't work are simply wrong," Cullerton said.

Although Cullerton introduced a mandatory helmet bill during the 1993 spring legislative session, the ISMS-supported measure failed in committee.

After 1994, Illinois stands to lose another 3 percent of its road funding for each year legislators fail to pass a law requiring motorcycle riders to wear helmets. This loss of funds could total $30 million in three years, Schakowsky said.

But Schakowsky and Cullerton agreed that mandating motorcycle helmets goes beyond the potential loss of construction funds. "It's an issue of life and death, as well as dollars and cents," Schakowsky said. "The use of helmets is the single most important factor in rider survival."

A 1988 University of Illinois at Chicago study revealed that only 15 percent of injured motorcyclists wore helmets, according to a Rehab Institute fact sheet. Motorcycle riders who did not wear helmets and were involved in crashes were three times as likely to suffer head injuries as those who wore helmets.

Motorcycle crash victims often face permanent disabilities or death, according to physicians who treat these patients. One such disability, traumatic brain injury, affects 1 million people annually. According to Rehab Institute officials, 70,000 TBI patients each year sustain permanent physical, intellectual and behavioral problems.

"Physicians have a strong mandate to prevent terrible disabilities," said Henry B. Betts, MD, Rehab Institute medical director and chief executive officer, and a strong supporter of mandatory helmet laws. "Accidents are preventable, and physicians have a role to try to prevent them.

"Death is very cheap, but disabilities are quite expensive," Dr. Betts continued, noting that caring for one head-injury victim can cost as much as $9 million over the patient's lifetime. "There is a considerable outlay of funds, not to mention the despair to the individuals and everyone surrounding them. It is clinically, philosophically and economically absurd and a great embarrassment that Illinois is one of only three states without a helmet law."

"Emergency room physicians share the deep remorse and grief that accompany preventable injury," said Karin Rhodes, vice president of the Association of Emergency Room Physicians. "We know a law would save lives, heads and money. Motorcycle helmet laws work."

According to the Illinois Department of Transportation, states with helmet laws experienced 30-percent decreases in motorcycle fatalities during the first year after implementing legislation. Illinois Motorcycle Helmet Coalition statistics showed that when Louisiana strengthened its law, the state's fatality rate for motorcycle crashes declined 44 percent. Conversely, when South Carolina and Wyoming weakened their helmet laws, the states' fatality rates increased 184 percent and 73 percent, respectively.

Most people don't understand how serious head injuries can be, said Bob Popovich, vice president of the Illinois Head Injury Association, whose son was severely injured in a 1986 motorcycle crash in which he did not wear a helmet. Popovich described some common TBI symptoms as loss of consciousness and bowel and bladder control, and inability to speak, understand and remember. Each symptom can last for a few minutes or forever, he said.

"Statistics show that the chances of avoiding fatality in an accident increase by 40 percent if the rider wears a helmet," Popovich said. "Probably all of us would wear a helmet if we played the slot machines on the riverboats or in Las Vegas [and] someone told us that doing so would increase our chances of hitting the jackpot by 40 percent. For some reason, many motorcyclists don't seem to realize that the biggest jackpot of all is to continue living normally."

"We sometimes get caught up in throwing numbers around," Cullerton said. "But it's the human side we must remember." ■

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82465	Cholesterol, serum; total
82550	Creatine, (CK), (CPK); total
82565	Creatinine
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83540	Iron
83615	Lactate dehydrogenase (LD), (LDH)
83735	Magnesium
84075	Phosphatase alkaline
84100	Phosphorus inorganic (phosphate)
84132	Potassium; serum
84155	Protein, total, except refractometry
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84478	Triglycerides
84520	Urea nitrogen, quantitative
84550	Uric acid; blood, chemical

(Issue: 11/05/93 - DB)

Flu shots recommended for elderly, chronically ill

PREVENTION: State and local public health departments begin their annual influenza vaccination campaign. By Anna Brown

[SPRINGFIELD] Illinois physicians should begin to see more patients seeking flu shots following a recent Illinois Department of Public Health advisory. In particular, senior citizens and individuals with chronic illnesses were encouraged to receive their annual flu shots as soon as possible.

Each year, the flu and related complications contribute to 10,000 to 20,000 deaths nationwide, including nearly 4,000 Illinois residents, according to IDPH. People over age 65 are at higher risk for complications and death from flu, the department said.

Although flu shots may not always prevent illness, they often reduce the severity of symptoms and protect against complications. IDPH recommends vaccinations primarily for individuals at high risk for developing complications, including seniors and patients with chronic lung diseases, such as asthma, chronic bronchitis, emphysema, tuberculosis, bronchiectasis or cystic fibrosis. Others at high risk are individuals with heart disease, severe anemia, diabetes or other chronic metabolic diseases or kidney disease, and patients whose immunity has been lowered through disease or treatment.

"We also recommend shots for those who come in contact with high-risk people," said Karen Greuter, an IDPH spokesperson. These include health care providers, family members and nursing home staff. "It can't hurt anyone to get the shot."

This year, the flu vaccine will protect patients against A/Texas, A/Beijing and B/Panama strains – the same three strains of flu that were present last year. To determine which strains of flu will strike, the U.S. Centers for Disease Control and Prevention studies strains present in the Southern Hemisphere, Greuter said. Since winter in the Southern Hemisphere occurs during the Northern Hemisphere's summer, scientists predict that similar strains will be seen above the equator during the Northern winter.

Although public health officials know which flu strains to expect, determining the severity of an approaching flu season is nearly impossible, Greuter said. "There is no way to tell until we start receiving reports."

The flu season typically runs from November through April. IDPH recommends that people get their vaccinations early to give their bodies time to build immunity to the illness. This process usually takes two weeks, Greuter said. But she cautioned that the department doesn't like to recommend vaccinations "too early in the year because protection will begin to wane by April."

THE COOK COUNTY Department of Public Health is also offering free vaccinations to suburban Cook County residents age 65 and older, chronically ill 3- to 8-year-olds who had a flu shot in the past and all chronically ill residents age 9 and older.

Because flu shots are now covered by Medicare Part B, CCDPH recommends that Medicare recipients obtain vaccinations from their private providers. "This new program provides more convenience for many seniors and allows the health department to focus on reaching those populations that do not have easy access to private physicians," said CCDPH Director Karen L. Scott, MD. Those populations include Hispanics, African-Americans and young people with chronic illnesses, she said.

"If the cost of the vaccine has been a problem in the past for those on Medicare, it should no longer have any bearing on their ability to be protected against the flu," added IDPH Director John R. Lumpkin, MD.

The Cook County health department expects a small decline in the number of people seeking free vaccinations at its clinics because of the Medicare coverage, said Caryn Cieplak, a CCDPH spokesperson. "Last year, we had virtually no publicity, and we saw just under 15,000 people. The year before we had high publicity and massive amounts of a strong strain of flu." In 1991, the department vaccinated 17,000 people.

CCDPH is also instructing Medicare patients to bring their Medicare cards with them when they get vaccinations at a department clinic. "Asking people to bring their cards keeps them in the habit of bringing them," Cieplak said.

Local health departments purchase the vaccine from IDPH, Greuter said. Medicare recipients should contact their local health departments to see if they offer free vaccinations or if they have Medicare provider status. "A lot of local departments provide vaccine free," Greuter said. "It's up to them." ■



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EDITORIAL

Open season continues

The debate on health system reform has rightly identified such problems as access. But it has also created open season on physicians, and doctors are the game. Some of the media are portraying physicians as the source of serious, pervasive problems in health care delivery and implying that patients require protection from their doctors. This distortion is dangerous because it erodes patients' confidence in their physician and violates the physician-patient relationship.

On a recent TV news program, a segment featured a physician who had been sued many times for malpractice. The interviews were primarily with some patients who had sued the doctor and a representative for the book *Questionable Doctors*, published by the Public Citizen Health Research Group.

The reporter alleged that the physician exemplified deficient training and clinical judgment. However, the show went further, implying that flagrant deficiencies are a widespread problem in the practice of medicine and that patients are at great risk when they receive health care.

Of course, state disciplinary boards should – and do – deal with bad doctors and malpractice. Information about disciplinary actions in Illinois are distributed by the Illinois Department of Professional Regulation and are published in *Illinois Medicine*.

Questionable Doctors, the publication touted on the program, is a compilation of disciplinary actions taken against physicians, dentists, chiropractors and podiatrists nationwide. Some of the actions included are unrelated to patient care, and some citations have been reversed on appeal. But no one mentioned that the information in such laundry lists is not always reliable, representative or meaningful.

At its September meeting, the ISMS Board of Trustees passed a resolution regarding physician-specific data. The resolution states that the Society supports AMA recommendations that this data should be collected and disseminated according to certain guidelines. For instance, the information should be used primarily for the education of consumers and physicians. In addition, there should be effective safeguards to protect against the release of "inconsistent, incomplete, invalid, inaccurate or subjective" data. And the methods for collecting and analyzing the data should be disclosed to physicians under review and to the public.

Unfortunately, the program failed to mention organized medicine's desire for the release of reliable information according to guidelines. In fact, no one from a state disciplinary board or medical group was interviewed on camera. At the end, the newscaster read a statement from the AMA calling the book "grandstanding." The lack of balance in the piece probably left viewers feeling fearful, playing on their uncertainty about the coming changes in the system.

Especially because of this public uncertainty, we should all make a special effort to help patients understand the real issue.

PRESIDENT'S LETTER

Taking reform personally

By Arthur R. Traugott, MD



We told legislators how important it is to preserve the physician-patient relationship and to avoid sacrificing patient care in the name of reform.

Critics fear health rationing," "Clinton tells doctors: Don't fear," "Doctors rebel over health plan in major challenge to president," "The health plan's financing gap." These are just a sampling of recent headlines from health system reform stories in the news. This saturated media coverage is undoubtedly helping shape public opinion on reform.

Through our "Health Reform: Taking Charge of Change" campaign, ISMS is also helping shape opinion by informing legislators of physicians' concerns about the Clinton proposal. Specifically, I was part of a group from ISMS and the Chicago Medical Society that met with the Illinois congressional delegation in Washington soon after the proposal went public. We discussed the problems of increased top-down federal bureaucracy and global budgets, and the need for stronger malpractice reforms and antitrust reforms. But first and foremost, we told legislators how important it is to preserve the physician-patient relationship and to avoid sacrificing patient care in the name of reform.

As important as these meetings are, they form only part of the whole picture we convey to our patients and legislators. The rest of the picture is made up of individuals like you, as you write your federal lawmakers and talk to your patients.

But, you ask, isn't legislative advocacy one of the reasons I belong to the AMA, ISMS and my county medical society? Yes, and professional groups do make a difference. But organizations are sometimes seen as being self-interest groups, and their objectives may be viewed with suspicion. That's why it's so important that we explain our role as patient advocates and supplement organizational activities with individual input.

Remember the recent state legislative session? Although former ISMS president Dr. Arvind Goyal and I testified for ISMS on your behalf on caps on noneconomic damages, your letters and calls helped the caps bill pass the Senate.

Now that reform legislation has been introduced in Congress, your federal legislators need to hear from you regarding reform. By now, you should have received an ISMS analysis of the proposal. *Illinois Medicine* also provides coverage in this issue, beginning on the first page.

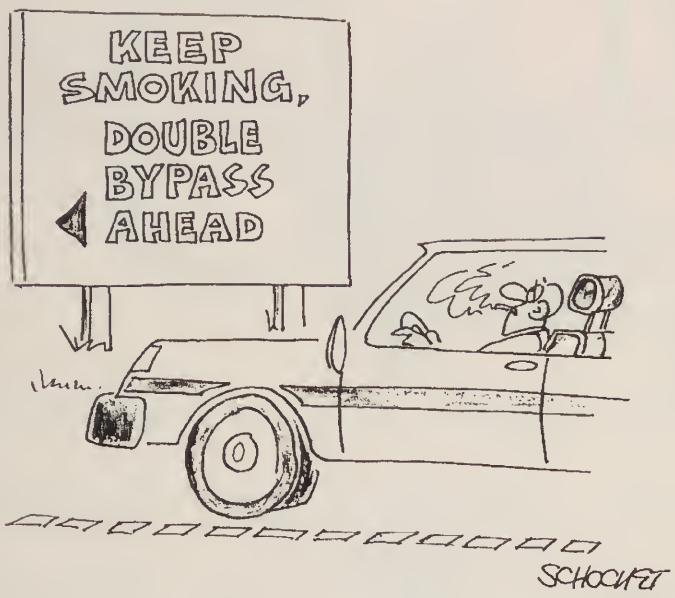
In the Clinton proposal, new governing bodies would monitor compliance with federal mandates, issue budget regulations, develop quality improvement and accountability information, and rate the performances of individual plans. Does this sound like added levels of bureaucracy? You bet. We're all too familiar with the hassles that already impinge on the physician-patient relationship, allowing us too little time to practice medicine. Extensive and complicated federal bureaucracy would only worsen the situation.

Even worse, health care providers would be excluded from these governing bodies. So clinical decisions would be monitored and rated by groups that lack the clinical training and expertise of physicians. This, too, would influence patient care, if physicians were forced to implement decisions that went against their best clinical judgment.

Global budgeting limits spending and therefore available resources for patient care. However, the cost-saving area of tort reform isn't adequately addressed. In particular, caps on noneconomic damages are essential to prevent excessive verdicts and the payout of millions of dollars not directly related to health care.

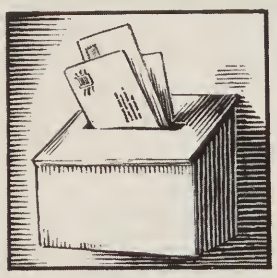
Please help ISMS educate your patients and inform your legislators so that your message is heard over the prolific – and often confusing – media coverage.

In addition, we need you to help us by completing the ISMS "Medical Practice Characteristics Survey," which was recently mailed. The results will help shape the Society's efforts to respond to the challenges of health system reform.



LETTERS

Joe Camel hides behind free speech



The tobacco industry is again crying "First Amendment Rights" now that the Federal Trade Commission is considering whether to banish Old Joe Camel. This dispute is not about the First Amendment, but the illegal marketing of a dangerous and deadly product to children. R.J. Reynolds is merely using the First Amendment as a sand dune for Old Joe to hide behind.

In response to the FTC's recommendation to ban Joe Camel ads, a spokesman for R.J. Reynolds said, "If we believed for a minute that the camel ad induces children to smoke, we wouldn't wait for the FTC or anyone else to act. We would immediately change the campaign."

Yet, according to a study in the *Journal of the American Medical Association*, within the first three years of the Joe Camel campaign, Camel's market share among children rose from .5 percent to 32 percent.

It's been two years since that study was published. Since then, R.J. Reynolds has moved only to increase the camel's visibility. And each day, 3,000 more children will puff on their first cigarette.

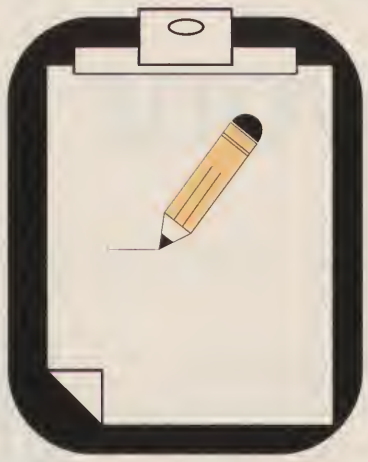
This is not about First Amendment rights. It is about greed. The tobacco industry simply wants to plant a fresh crop of addicted children to replace the 400,000 smokers that die each year from tobacco-related illnesses.

Until Joe Camel is banned, the American Medical Association will continue to exercise its First Amendment rights to speak out about the deplorable advertising practices of the greedy tobacco industry.

– John L. Clowe, MD
AMA immediate-past president

Illinois Medicine *welcomes letters on topics covered in the newspaper. Send letters to* Illinois Medicine, *20 N. Michigan Ave., Suite 700, Chicago, IL 60602. Letters will be edited for space and style.*

ISMS surveying Illinois physicians



To better respond to physician concerns raised during the health system reform debate, ISMS is conducting a survey of Illinois physicians regarding their practice characteristics. The survey was sent to all practicing Illinois physicians, not just ISMS members, to ensure that the information represents the state's entire physician population. Individual physician responses will be kept confidential; only aggregate results will be reported. Information obtained through the survey will be used to strengthen the Society's efforts to educate the public and government leaders about how certain proposed reforms would help or hinder health care delivery. Physicians are urged to complete the survey and return it in the accompanying envelope by Nov. 15, 1993.

GUEST EDITORIAL

Dispatch from the front

By Stuart N. Speer

Bombs whistle down from droning swarms of planes. Ack-ack guns beat a rhythmic tattoo to the dying moan of a siren as it cringes past the shriek of its ascending mate. The acrid smoke of battle parts to reveal a man; a common man, caught in extraordinary circumstance. Survival is his only design, getting through the morning his only goal.

His glazed eyes begin to clear, a competing reality shakes him by the shoulders. The smoke has vanished. And the sound: It isn't the ack-ack, it's the staccato rattle of the clinic's computer printers hammering out past-due notices. The bombs are gone too, replaced by the heavy thud of "Health Care Provider Updates," four of which the mail carrier has just dropped on the reception desk. All of the terror, none of the glory.

Once again, nerves are fraying. Siege mentality is returning to the battle-hardened office manager. The onslaught of raids is due any second. Daredevil fliers of the third-party-payer bomber wing have broken through, zeroing in with their small but cunningly delivered havoc. Searchlights trace a cat's cradle in the sky, hunting the dread HCFA bombers. The newest weapon – the RBRVS buzz-bomb – wreaks random destruction – and general terror – while rumors persist of the development of a Hillary V-2.

Ragged and dazed, his crew assembles for a brief prayer. Most have given up hope, and it shows in their eyes. How they continue no one knows. Raw courage.

Then, the order comes down: "Fix bayonets. Open mail."

It becomes clear immediately that casualties are heavy. Of the claims that had been sent off to negotiate – young and handsome on their bright red forms – 32 have returned, torn, marked and stained. These were clean claims, blameless, yet here they lay, senselessly mutilated by an unseen hand.

"The Geneva Conventions be damned," snarls the OM. "This savagery wants revenge."

The chief doctor takes two quick strides across the room and slaps the OM across the face, sharply. Shamed, and contrite, the OM mutters, "Thank you, sir. I'm all right now."

The casualty report is bad, but it is nothing compared with the devastation that follows.

"Our No. 3 HMO has issued another series of identifying numbers for the doctors, effective immediately," groans the grizzled insurance clerk.

"Lemme see that," the OM snaps. "That can't be right. They already have two numbers each to ID ... No! No! No!"

"Get onto the software company. Tell them we've taken another hit. We'll need an immediate rewrite. Call Marge and tell her we'll need more rubber stamps. Move it, move it, move it!"

The creaking machinery of the vastly outgunned office once again struggles to answer the call, while the chief doctor (who has retired to the war room) tries to focus on the Big Picture, tries to formulate a strategy.

"I just don't see it," he mutters to himself. "Without reinforcements, it's a matter of weeks ... months at the most. No respite, no good news. 'Bad news' is mere redundancy, and the complexity ... no, that's too reserved, it is chaos."

He looks at the numbers again.

1. One hundred forty-seven 1099 tax forms. Each one representing an insurance company with which he did business in 1992. Each company with its own rules, its own contracts – its own dive bombers.
2. One, two, no 10,000 regulations from CLIA, from OSHA, from state, local and fire inspectors. All with their own threats, all are sitting in the waiting room.
3. It has been years since even his CPA could explain retirement plan regulations, yet there THE PLAN sits, waiting to be reported to a pack of meat-eating bureaucrats.
4. Diagnosis, procedure and treatment codes swirl in a mad jumble of shifting signs and numbers, here coalescing, there diverging.
5. ...

No, he can't go on. It's all just too grim. This isn't why he got into medicine! He got into medicine to ... ahh ... to what?

"I know it wasn't for this. It was for Mom ... no, not Mom, she wanted me to be an adagio dancer. Wait a minute. Patients! Yes, that's it. Patients. Sick people."

Leaning over his desk, he picks up the phone and presses the intercom button.

"Any patients?"

"Yes, sir," comes the tremulous reply. "Mrs. Buxley is here. With her attorney. Your 9:30 is here and wants to know if we accept Argentinean workers' compensation cards. A man who says he's your neighbor is here. No appointment, but he wants to know if you could look at something on his hand. There's also a delivery man who apparently has a PPO regulation book in his semi and needs some help carrying it in."

The physician's once-steady hand places the receiver back in its cradle, or at least near it. He rises, straps on his stethoscope, swallows – straight from the bottle – a week's ration of Maalox and opens his office door.

The sound of battle awaits him. It's near, maybe 20 feet away. He shrinks automatically back into his office, then gathers his courage and steps out again. There is no hesitation now, just a shrug of resignation, as he slopes toward the clinic door.

"To some generations, much is given," recites the rapidly aging medico, and through the door he marches: a date with destiny.

Speer is from Shawnee Mission, Kan.

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PAGE 7

ISMIE Update

ISMIE board briefs

PAGE 10

Medical malpractice climates in the United States, Canada and Great Britain

TORT REFORM: Experts discuss the legal, ethical and economic perspectives in these countries. By Gina Kimmey

[CHICAGO] Whether practicing in a U.S. city, a Canadian province or the English countryside, physicians know the fear of having to defend a malpractice claim. But nowhere is that fear as prevalent or daunting as in the United States, experts agreed Oct. 21 during Loyola University's fourth annual Comparative Health Law Conference. Legal and medical experts speaking at the two-day conference in Chicago discussed the issues faced by plaintiffs and defendants in medical malpractice cases proceeding through the U.S., Canadian and British tort systems.

All three countries are experiencing increases in the frequency and severity of medical malpractice claims, speakers said. But in Canada and England, where the health care systems are run by the government, there are generally no personal contractual arrangements between physicians and their patients. The tort systems in those countries have built-in safeguards to discourage the type of widespread medical malpractice crisis the United States has experienced, according to the presenters.


Amy Rothblatt

LeBlang

The parameters defining a medical malpractice claim in the United States have continually expanded, said Theodore R. LeBlang, JD, professor of jurisprudence and chairman of the department of medical humanities at the Southern Illinois University School of Medicine. He cited a case of a physician who performed surgery on a patient without disclosing his HIV status and whose estate was subsequently sued. The patient tested negative for the virus, and the court accepted as fact that transmission of HIV from a surgeon to a patient when all necessary precautions are taken is only a theoretical possibility. But the trial judge ruled that the plaintiff's fears, characterized by headaches and mental anguish, constituted legally compensatory damages.

In another case, a physician performed what turned out to be an unsuccessful vasectomy, LeBlang said. When the patient's wife became pregnant, she sued her husband's physician. The state court ruled that the woman's claim was legally supportable, even though there was no physician-patient relationship between her and the doctor.

"These cases exemplify the manner in which state courts have broadened physicians' exposure to liability," LeBlang said. Cases based solely on emotional distress or on expansion of the physician-patient relationship are causing more nonmeritorious claims, higher insurance premiums for doctors and hospitals and significantly higher costs for the country's health care system, he added.

COURTS IN THE CANADIAN provinces do not have the authority of state courts in the United States, said Joan M. Gilmour, professor of law at Osgoode Hall Law School at York University in Ontario. In Canada, plaintiffs in medical malpractice cases must prove that the defendant-physician owed the patient a "duty of care," failed in that duty and caused injury to the patient. In defending themselves, physicians are responsible only for proving they did not breach the accepted standard of care.

There are also procedural differences between the Canadian

(Continued on page 10)

MALPRACTICE ROUNDUP

TV ads convinced patients to sue

A survey of 502 patients who said they wanted to sue their physicians found that the idea to file a lawsuit originated from television commercials by law firms, *Physicians Weekly* reported. The survey was conducted by Med-Law Case Review, an Oklahoma City consulting firm that works with plaintiff and defendant bars.

Interviews were conducted with 502 of 730 patients who called six law firms on 10 randomly selected days in 1991. For many of the patients surveyed, the television commercials turned a poor relationship with a physician into a malpractice suit, said a spokesperson for the consulting firm. However, if the injured patient was a baby or a child, even a good relationship with a physician didn't stop a person from deciding to sue, according to the survey.

The survey also revealed that patients with low incomes and large medical bills were likely to sue their physicians. Patients' insurance status was not a factor in their decision to sue, the study found. In addition, patients said they wanted to sue if they thought the doctor failed to keep them fully informed, to consult them about problems and to refer them to specialists when needed. ■

Doctor's AIDS leads to battery claim

A patient who undergoes surgery by an AIDS-infected physician and who doesn't know about the doctor's condition can sue for battery, even though the patient tested negative for HIV, according to a California appeals court. As reported in *Medical Malpractice Law & Strategy*, the court ruled that the patient had a legitimate claim for her fear of contracting AIDS.

The court found evidence to support the patient's claim that she asked about the physician's health before surgery, because she feared exposure to AIDS. According to the ruling, the plaintiff's fear of having contracted AIDS between the time she learned of the doctor's HIV status from a news broadcast and the time she received her test results was legitimate. The appellate court decision reversed the trial court ruling, which had granted summary judgment for the defendants, including the doctor's estate, his medical partners and their practice. ■

No anesthesiologist during Cesarean

A child can recover for loss of a parent's consortium if a permanent injury occurred that destroyed or nearly destroyed the parent-child relationship, a Montana court ruled.

According to a case reported in the *Malpractice Reporter*, a mother was admitted to the hospital in active labor in her 38th week of pregnancy. The baby was in a transverse lie position that would very likely require delivery by Cesarean section. Anesthesiologists at the hospital were available only on call, and hospital procedure required staff to allow anesthesiologists 30 minutes to arrive at the operating room after the initial call. The physician failed to call an anesthesiologist when he learned of the fetal position. When the patient's water broke, an immediate Cesarean section was required, which was performed with only a local anesthetic.

The court ruled that the child could recover for loss of the parent's consortium resulting from the mother's injury, which was caused by the physician's failure to obtain timely anesthesia services. ■

An international comparison of selected health care data, 1990

	Total health expenditures as a percent of gross domestic product	Per capita[1]	Average length of stay in inpatient care institutions
Canada	9.3	1,770	—
Germany	8.1	1,486	—
Japan	6.5	1,171	50.5
Sweden	8.6	1,451	18.0
England	6.2	972	14.5
United States	12.1	2,566	9.1

[1]In U.S. dollars, measured in gross domestic product purchasing power parities

Source: *Health Care Financing Review*, 1992

Malpractice climates

(Continued from page 9)

and U.S. tort systems that provide less incentive for patients to sue their physicians, said Gilmour. Although the severity of claims is increasing in Canada, there are no "runaway jury awards," she said. Judges, not juries, decide cases. And, in 1978, a cap of 100,000 Canadian dollars, which at today's exchange rates would be $80,461.50 in U.S. currency, was placed on noneconomic damages. "The theory behind the cap is that there is no sense in awarding large amounts of money for noneconomic damages," said Gilmour. "No amount of money could truly compensate for pain and suffering."

In addition, the contingency fee system is not as widely used in Canada as it is in the United States, and Canada has adopted the English rule of cost awards – the loser pays the winner's legal costs. Further, class-action suits are rare in Canada, because even minor differences among individual claims can disqualify them for a class action, Gilmour explained.

THE ENGLISH TORT SYSTEM is one of a few systems worldwide that still do not recognize "informed consent," according to John S. Hodgson, a practicing solicitor and principal lecturer at Nottingham-Trent University in Nottingham, England. English medical malpractice cases are based on negligence and the accepted standard of care, called the "Bolam test."

Hodgson said the Bolam test requires physicians to prove they practiced the "standard of the ordinary, skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."

As an example, he cited a recent case in England involving a woman who underwent a breast biopsy. When the patient awoke after surgery, she found the physician had performed a radical mastectomy. The doctor argued that he had discovered advanced cancer during the biopsy and determined a mastectomy was necessary. According to English law, the physician had no duty to obtain informed consent as long as he followed the accepted standard of care. The case is pending.

The English approach to awarding damages is also different, Hodgson said. "One key distinction is that juries are not involved. You can't impress a judge with a sob story. There is a body of established case law that indicates the parameters for awards, and it is respected by the judges." England has capped noneconomic damages, limiting awards at $153,055 in U.S. dollars.

More than 90 percent of Canada's 54,000 physicians belong to the same organization from which they receive full indemnity protection and membership representation. Their coverage carries no deductibles and has no limits. Annual membership dues for pathologists, including insurance premiums, are $804.62 in U.S. dollars, and for orthopedic surgeons and neurosurgeons, $13,678.46 in U.S. dollars, Gilmour said. In 1992, Canadian physicians reported only 4,000 incidents that could possibly have resulted in malpractice claims. And only 1,000 medical malpractice claims were filed in Canadian courts.

In England, annual medical malpractice costs run an estimated $76.5 million to $84.15 million in U.S. currency, and these costs are expected to increase 20 percent every year. The National Health Service is receiving more complaints about physicians than ever before, and complaints lead to litigation, said John H. Tingle of the Nottingham-Trent University Law School.

"The problems in England are worse than they used to be, but not nearly as bad as they could be," said Hodgson. "It is clear that we share many of the same problems, but we have very different answers for them." ■

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ISMIE BOARD BRIEFS

The ISMIE Board of Governors met Sept. 10 at the ISMS Conference Complex in Chicago. The following are meeting highlights:

Reaching out to policyholders

Members of the ISMIE Board of Governors are reaching out to policyholders through meetings with hospital medical staffs, clinics, county medical societies, residency programs and specialty societies. The outreach effort is an integral element of the Exchange's Physician-First Service program. Presentations are available on the specifics of ISMIE policies as well as on the professional liability climate in general. For more information, physicians may call ISMIE at (312) 782-2749 or (800) 782-ISMS.

ISMIE maintains market share

As of July 31, ISMIE policyholders numbered 10,729, compared with 10,702 in July 1992 and 10,714 in July 1991. These totals include individual policyholders and corporate and clinic policyholders. ISMIE offers reduced rating programs to groups of physicians with favorable loss experience. To receive a premium quote, policyholders may contact ISMIE's underwriting department.

Policy review under way

Since 1976, the language in ISMIE policies has been revised only occasionally to address specific concerns. Consequently, the Exchange is beginning a comprehensive, detailed review of policy language. The review will also help determine whether policy language can be clearly understood by the company's physician-insureds.

Claims checkup conducted

As part of its continuing effort to provide physician-first service, ISMIE has asked policyholders to evaluate Exchange claims-handling procedures and personnel, including defense attorneys. ISMIE will use data gathered from the survey responses as a basis for improving overall claims service. Completed survey forms are confidential. Policyholders are encouraged to call ISMIE if they have questions or concerns about the survey or any aspect of their coverage.

ISMIE explains Best rating

ISMIE received an NA-6 rating from A.M. Best, because Best does not rate all of the Exchange's international reinsurers, according to ISMIE Board Chairman Harold L. Jensen, MD. Companies that are rated by A.M. Best tend to use U.S. reinsurers, Dr. Jensen said. However, ISMIE has maintained a long-term, stable relationship with European- and London-based reinsurers. Many U.S. reinsurers left the market in the mid-1980s, while the London reinsurers used by ISMIE remained. Dr. Jensen stressed that policyholders who are concerned about ISMIE's Best rating should be aware that the Exchange has continually passed the 11 stringent financial tests of the National Association of Insurance Commissioners, which are designed to measure financial security. ■

ISMS BOARD BRIEFS

The ISMS Board of Trustees met Sept. 11 at the ISMS Conference Complex in Chicago. The following are highlights of the board's actions:

ISMS addresses physician concerns in reform proposal

Using the theme "Health Reform: Taking Charge of Change," ISMS launched an awareness campaign aimed at educating physicians about health system reform and patients about becoming responsible for making wise health care decisions. ISMS kicked off the effort with an all-physician mailing analyzing President Clinton's reform proposal. As the reform process continues, ISMS will hold physician speaker training sessions, town meetings and media briefings. In addition, the Society is developing information kits for physicians and their patients to use in evaluating reform proposals. ISMS is also participating in a study with other state medical societies and the AMA to identify ways organizations can meet the challenges presented by reform.

Amicus brief filed to protect confidentiality

A lawsuit filed against the Illinois Department of Public Health could open the door for plaintiffs to explore confidential reports made to the department. ISMS will file an amicus brief in *May vs. CIPS* to emphasize to the court the need to maintain confidentiality. The plaintiffs in this case are seeking confidential medical records that IDPH had collected as part of an investigation of four Taylorville children who contracted neuroblastoma, a rare childhood cancer. The plaintiffs claim that coal tar stored in underground tanks at an abandoned utility plant caused the cancer cases, and they are suing the utility company. IDPH found no environmental link for the cancer cluster.

Protections sought for physician-specific data

An ISMS resolution stressing the importance of safeguarding physician-specific data has been submitted to the AMA House of Delegates for consideration at the December interim meeting in New Orleans. According to the resolution, only valid, accurate and objective information should be released to the public if it is to be used to educate consumers and physicians. In addition, the ISMS resolution calls for implementation of safeguards to prevent the unauthorized use or disclosure of physician-specific data.

ISMS to update medical discipline information

ISMS will update its information packet covering the medical disciplinary process in Illinois. The kit will explain how ISMS-supported changes to the Medical Practice Act of 1987 strengthened the state's licensing and disciplinary procedures. The information is targeted at physicians, their patients and the press. The packet will also include tips to help patients choose a physician and determine what to do if they suspect their doctor is impaired.

Society's loan fund helps medical students

ISMS approved $275,000 in student loans for the 1993-94 academic year. The loans will be awarded to students attending eight Illinois medical schools. To promote careers in primary care, ISMS waived the 5.5-percent loan fee for 20 students who have made a commitment to specialize in primary care. Since the inception of ISMS' student loan program in 1983, 98 percent of the loans issued have already been repaid or are being repaid on schedule.

Physician assistance presentations available

The ISMS Physician Assistance Committee is offering presentations on physician impairment to county and specialty societies, as well as hospital medical staffs. The programs address how family members, friends and colleagues can recognize and deal with physician impairment. ISMS and the Illinois State Bar Association will cosponsor an interprofessional conference on impairment Nov. 19 at Loyola University in Chicago.

Medical student seeks AMA board post

Michael Suk, a third-year medical student at the University of Illinois at Rockford, was endorsed by the ISMS board to run for the medical student position on the AMA board of trustees. The election will be held during the AMA annual meeting in June 1994.

ISMS adopts policy on CME sponsors

The board approved policy regarding the intrastate CME accreditation status of hospitals when two or more institutions merge. The policy outlines recommendations for deciding whether post-merger programs must undergo a new site survey. According to the policy, the degree of change in the sponsor's CME committee is the most crucial factor in making such a decision. Other factors include the relative size of the merging entities and the new corporate identity, as well as changes in the medical staff, its bylaws and the audience served by the entity's program. ■



Matt Ferguson

LEARNING THE different ways humans use their hands is the focus of an exhibit at the Chicago Children's Museum. The display, sponsored by the Ingalls Hospital Center for Rehabilitation Medicine in Harvey, also shows how rehabilitation helps people with disabilities. Children can simulate the difficulties of being disabled by using the exhibit's thumb immobilizer.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

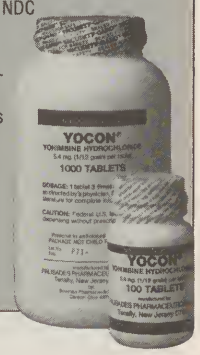
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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VIOLENCE AGAINST WOMEN

Revealing the faces of domestic abuse

Physicians can learn to recognize the symptoms of an epidemic that strikes 300,000 Illinois women each year.

BY GINA KIMMEY

The most common – and least reported – crime in the United States is responsible for 22 percent to 35 percent of women's emergency room visits. It is a crime inflicted on one woman every 15 seconds and 300,000 Illinois women every year. Annual medical treatment of victims' injuries costs more than $44 million. And, sadly, the victims of this crime suffer at the hands of people they love. The crime is domestic violence.

Through their new Anti-Violence Initiative, ISMS and the Auxiliary are trying to address this epidemic. The program aims to help physicians identify the signs of domestic violence and provide them with educational resources so that they can better serve their patients who are victims of abuse. The program was officially launched at the Auxiliary's Oct. 6 Women's Health Seminar, during which physicians and legislators discussed ways to combat domestic violence through awareness, education and action.





Photos by John McNulty

You could be closing your eyes to the fact that this woman will most likely return home only to be beaten again and again.

"We know that one in 10 battered women receives care in emergency rooms," said Sangamon County Medical Society President Jane L. Jackman, MD. "There are many times when doctors could intervene. But domestic violence often goes unrecognized. Because doctors don't suspect it, they don't ask the right questions. In addition, patients don't tell. I think if doctors were more aware of what to look for, we could intervene and prevent the escalation to serious injury or death."

According to Dr. Jackman, domestic violence victims don't always have bruises and broken bones when they see a physician. Instead, they often present with multiple body aches for which they have no explanation, headaches, chest pains, anxiety or depression, or low self-esteem – injuries that don't readily arouse suspicion.



We have to look for things that don't add up, we have to be suspicious, and then we have to ask questions.

Many physicians have seen patients who suffer from domestic violence, but they may not have recognized them as abuse victims. Sandra F. Olson, MD, a neurologist at Northwestern Memorial Hospital and president of the Chicago Medical Society, is one such physician. She had been seeing a married female patient in her mid-20s who was suffering from migraine and tension headaches. After repeated visits and several treatments that failed to cure the headaches, the patient finally told Dr. Olson that she was a battered wife.

"It's something I had never suspected," Dr. Olson said. "I hadn't asked the right questions. I simply tried to see her from the scientific eyes I had been trained to see with as a neurologist. I pride myself on trying to know my patients and look at them as human beings, as whole persons, but I really missed the boat on this one.

"We, as physicians, have to know what are the symptoms and signs of this particular illness," she continued. "We have to know patterns, we have to look for things that don't add up, we have to be suspicious, and then we have to ask questions."

AS CHAIRMAN of the Illinois Senate Health and Welfare Committee and a member of the Senate Judiciary Committee, Sen. Judy Baar Topinka (R-North Riverside) told program attendees that "one way or another," she is likely to see all bills introduced in the General Assembly involving domestic violence. And she will be actively interested in them.

"As women, we react to domestic violence more strongly than men do, because, more often than not, domestic violence happens to us," Topinka said. "It has probably happened to people in this room, or their moms or their daughters, or it may happen. It is something that adds to the fear factor – the silent fear that we all have as women – that when we get up in the morning, our world is just a little bit more dangerous than that of men."

Too often, society blames victims, Topinka said, adding that people typically don't understand women's resistance to leaving abusive situations. But she said that women stay in abusive relationships because of myriad, complex reasons, such as fear, lack of self-esteem or concern that the abuser will retaliate. For many women, the abusive partner is their sole source of financial support or housing. In addition, these women often have small children and cannot risk leaving their home with no promise of food or shelter. These factors serve to make women prisoners in their own homes, Topinka said.

"These are silent victims," Dr. Olson explained. "They don't come in with the claim that they are victims of violence. We can set the fractures, we can treat

(Continued on page 14)

When they can't go home

The world is full of suffering, but it is also full of the overcoming of it," said Alice Nathan, executive director of Sojourn Women's Center in Springfield, quoting Helen Keller. Nathan spoke at the ISMS Auxiliary's Women's Health Seminar last month.

"If you think domestic violence is not happening on your block, take another look – it doesn't just happen to the poor, the uneducated and the racial minorities," said Nathan. "Domestic violence is the leading cause of injury to women [in the United States], accounting for 16,000 injuries and 4,000 deaths every year. That's more than automobile accidents, muggings and rapes combined.

"Every 12 to 15 seconds, a women is beaten by her husband or boyfriend," added Nathan. "This is suffering at the hands of someone you love. This is preventable suffering."

Providing a haven for abused women and their children, Sojourn often has a waiting list of women seeking shelter from domestic violence. The average length of stay at the center is eight days, but some women stay several months, depending on their circumstances. During that time, women receive counseling to help them decide what they want and need to do with their lives, said Nathan. Their children are enrolled at the nearby elementary school, which has created a special class for them. They receive more stability and individualized attention than in the average classroom setting, Nathan said.

Unfortunately, many of Sojourn's women return to their abusers, said Nathan. But those who stay for longer periods of time have usually made the decision not to return and are waiting for money or seeking housing or employment. The center works with domestic abuse shelters nationwide, coordinating an underground network to move abused women and their children across the country and as far away from the abuser as possible.

Funded by donations, as well as state and federal money channeled through public aid and the Illinois attorney general's office, the center provides all its services free. The center also provides information on shelters statewide. For information about the nearest domestic violence shelter, physicians or their patients may call Sojourn Women's Center at (217) 544-0203. ■

—Gina Kimmey

Domestic abuse

(Continued from page 13)

the headaches, but that's not really the point. If we don't get them to talk about it, we are not going to find out what the real problem is."

According to Dr. Jackman, a physician's interaction with an abuse victim can have a tremendous effect. "She is searching for someone to believe her and possibly offer an alternative. An attack by a loved one is an emotionally shattering experience. She needs compassion, not criticism or condescension."

As an example, Dr. Jackman quoted from a guest editorial that was written by a physician-victim of domestic abuse and published in the *Journal of the American Medical Association*: "Abusive relationships do not start with violence. Women do not enter into a relationship saying, 'It's OK to hurt me.' Even abusive relationships start romantically, sharing love and trust, building dreams together and often having children. ... When I took my marriage vows I imagined for better or for worse, but when 'til death do us part became a frightening reality, I was faced with some terrifying decisions."

Physicians should also realize that domestic abuse is a long-term problem, Dr. Jackman added. Through her experiences with victims, she said she has found that just telling someone to leave an abusive relationship – even though that is the ultimate aim and treatment – doesn't work. "Realize that your actions, or lack of actions, can have a huge impact on your patient's life. Be aware that by not asking if domestic abuse is the cause of your patient's injuries, you could be closing your eyes to the fact that this woman will most likely return home only to be beaten again and again."

In the 10 minutes you took to read this story, 40 women became victims of domestic violence. For information about the Anti-Violence Initiative or to schedule a presentation on domestic violence, physicians may call (312) 782-1654, ext. 1241, or (800) 782-ISMS. ■

CME challenges

(Continued from page 1)

obtained close to home."

One of several influences on the types of CME courses offered will be the "drastic shift toward primary care over the next decade," Dr. Tan said. To increase the number of generalist physicians, more residency slots will be opened in primary care fields, he noted. At the same time, specialists need retraining to spend approximately 50 percent of their time delivering primary care. Specialty societies and primary care professional societies will develop CME programs geared toward this redistribution of skills, Dr. Tan predicted.

CME courses will also focus more on practice management, helping physicians organize their practices more efficiently and weigh the cost-effectiveness of their practice styles, Dr. Tan said.

Creating CME courses to meet those needs will present challenges and opportunities for academic centers, specialty societies and community hospitals. More CME courses will be offered by community hospitals and institutions, while specialty and academic programs charging up to $25 to $40 per credit hour will risk obsolescence, Dr. Tan said.

WITH DECREASING REVENUES, pharmaceutical companies will have less money to support CME programs. Dr. Tan noted that many drug companies are already reducing their CME staffs. While he anticipates that the educational collaboration between drugmakers and the medical community will continue, he warned that in the future, pharmaceutical company spending will be a "dribble rather than a gush."

As the nature of CME courses changes and pharmaceutical company funding diminishes, providers will depend more on cooperation. Mergers, consolidations, formal and informal consortia, and resource sharing will result in fewer but more appropriate and relevant CME offerings, Dr. Tan said.

Outside university and hospital settings, HMOs and PPOs are showing more interest in becoming accredited CME providers, Dr. Tan said. These managed care organizations will most likely be interested in sponsoring CME programs that train their physicians to be more cost-effective, he predicted.

In the near future, salaried physicians will probably spend a part of their workday on CME. According to Dr. Tan, that arrangement is already in place at Kaiser Permanente hospitals.

Kaiser's "chiefs of education" meet quarterly to discuss CME topics and speakers. Research regarding appropriate and judicious use of finite resources – whether it's drugs, instrumentation or procedures – generates a fair number of the CME programs, Dr. Tan explained.

"The CME community must engage in health care reform debates, develop coalitions and begin to build health care policy agendas that expand the role of CME as a cost-effective and politically sound mechanism for continuously enhancing the physician's lifelong learning and improving patient care outcomes." ■



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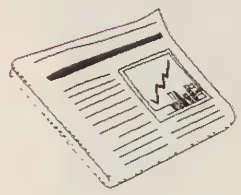
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Primary care

(Continued from page 1)

calls for adjusting Medicare rates to increase payments for primary care, while other physician rates decline. According to primary care physicians, such a change is necessary for a successful shift to primary care.

"There will have to be changes," said James D. Wright, MD, a Joliet internist. "In terms of compensation as well as respect, we have to make primary care more attractive to medical students."

Emalee G. Flaherty, MD, a Chicago pediatrician agreed. "Primary care specialists are the lowest-paid physicians in medicine. And when you come out of medical school $50,000 or $100,000 in debt, you don't want to go into a low-paying specialty. You need money to pay back your debts." But Flaherty said she believes that once medical students see where the new demand is, they may have more incentive to choose primary care.

"There is a preponderance of specialists right now, and that serves to drive up costs," said Dr. Wright. "[People] want to see a cardiologist if they are having chest pains, but chest pains aren't always the result of a heart condition. A primary care physician can point patients in the right direction through the medical maze and tell them if they need to see a specialist."

It has yet to be decided which physicians will be classified as primary care providers under the proposal. This issue is of particular interest to physicians such as Ob/Gyns who provide primary as well as specialized care for many of their patients.

"More than 80 percent of my practice involves providing routine Ob/Gyn and primary care to women in the reproductive age group," said Jeffrey N. Maurus, MD, a Moline Ob/Gyn. "I would say only 10 to 12 percent of my practice involves complicated, specialized Ob/Gyn care. Every day I provide Pap smears, as well as treat minor illnesses, give immunizations and do triage. If they don't allow my patients to see me for their primary care needs, there won't be enough primary care physicians to handle all the patients out there."

If all aspects of the proposal were successful, physicians might receive some relief from the hassle factors they so often face, said William S. Hulesch, MD, a family physician in Downers Grove. "All those questions we deal with on a daily basis – Does this patient have insurance? Can they afford care? Should I provide free care and free medicine? – would be eliminated, and we could get back to patient care.

"But my concerns involve big government," Dr. Hulesch continued. "I see how Medicare works, and frankly, I think it works OK. But then I see the [Veterans Affairs] system, which works very poorly, and I have to ask, Which way is health care reform going to go?"

Many primary care physicians agree that for any reform plan to be effective, patients must bear more economic responsibility. "Patients need to have more of an economic interest in deciding where and how to get their care," said Dr. Maurus.

"When patients are economically affected, they tend to be more interested, more involved," said Dr. Wright. "It is an effective way of getting them to pay attention to costs."

Providing universal access and focusing on preventive care should help keep patients from falling through the cracks, said Michael L. Brewer, MD, a Springfield family physician. "I think that overall care will improve, but the emphasis on people taking responsibility for themselves and their own health care, that's very important." ■



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Specialists

(Continued from page 1)

something very brave and sincere," said Jayasiri R. Fernando, MD, an Effingham radiologist. "But the plan won't be as simple as it sounds." Nevertheless, Dr. Fernando said he is "willing to undergo hardship to improve the country's health care."

Eugene C. Wittenstrom, MD, a St. Charles orthopedic surgeon, said he is trying to stay optimistic about the future of health care. "I want what's best for my patients and the medical profession. I would hate to see it get worse. If primary care is the way to control costs, that's the way it's going to go."

"There is still a large shortage of oncologists nationwide," said James L. Wade, MD, a Decatur oncologist. "The Clinton plan won't spell the ruin of my particular specialty. Primary care doctors will continue to work with us to get the most appropriate and cost-effective care."

But Dr. Wade noted that cost savings will be the only measurable gain of the Clinton proposal, since quantifying overall patient benefits will be difficult. "How do you measure health outcomes?" he asked, adding that the biggest challenge to the health care system will be changing patients' lifestyles. "Medicine has tried but has not had great success in changing lifestyles."

"The driving force of health care reform is cost containment," said William J. Robb, MD, a Glenview orthopedic surgeon. "There is a logical tendency to suggest we need more primary care, but it's not a global solution.

"I have some real concerns that specialists are seen simply as a cost society can't bear," Dr. Robb continued. "Primary care is a very important part, but it needs to be balanced with the value of specialty care. It's simply not possible to be a master of all trades as a primary care physician.

"It's critically important that the health care system maintain advances in such areas as technology," Dr. Robb added. Although technology carries a hefty price tag, society has benefited substantially from medical advances, he said. "The benefits of technology need to be brought fully into the picture as we begin to look to the future."

"With technology as it is now, people are going to be getting a lot more evaluations," said James W. McCriskin, MD, a Bloomington cardiologist. By allowing everyone unlimited access to care, the system could become overwhelmed, he added.

"The bottom line is that we will have some form of rationing," Dr. McCriskin said. "There will be an influx of patients into the system who will require diagnostic testing and referral." Consequently, primary care physicians will be exposed to much greater liability than in the past. "If you make the primary care physician the gatekeeper, you're going to have more gates to keep," he said. To counter that, patients must be allowed to flow through primary care to the specialists, he added.

> ***If you make the primary care physician the gatekeeper, you're going to have more gates to keep.***

Most specialists agreed that for the Clinton proposal to contain costs, it must include much stronger tort reform measures, especially caps on noneconomic damages in medical malpractice suits. "Without caps, we can't make effective inroads," Dr. McCriskin said, calling the threat of litigation the "constant monkey on every doctor's back. There is more defensive medicine being practiced than can be calculated. It only takes being burned once to put you on the defensive for the rest of your life." ■

ISMS takes action

(Continued from page 1)

Congressional sources indicated that debate will be long and involved and that the legislation is likely to be amended many times, Dr. Traugott said. "The focus of ISMS' efforts will be helping shape legislation. We encourage physicians to educate themselves and their patients about our most pressing concerns, so that we can ensure the best possible care for our patients under a new health care model."

As part of its "Health Reform: Taking Charge of Change" campaign, ISMS sent a complete analysis of the Clinton proposal to every Illinois physician. In addition, ISMS will conduct a series of town meetings throughout the state to foster a dialogue with the public. "These meetings will stimulate patient consideration of the questions and concerns we raise on health system reform," Dr. Traugott said. "Physicians also stand to gain valuable feedback at the meetings." Also, the ISMS Board of Trustees recently approved a series of regional speaker training sessions on health system reform.

ISMS HOUSE OF DELEGATES policy contains some elements that are included in the Clinton proposal – universal access; insurance reforms such as elimination of pre-existing condition limitations, use of community rating and portable coverage; a comprehensive minimum benefits package; CLIA modifications and administrative simplification, Dr. Traugott said. However, ISMS is seriously concerned about other elements of the proposal, he added. These include the potential for compromised patient care, the use of global budgets, Medicare cuts, the creation of excessive top-down bureaucracy, the lack of strong medical malpractice reforms and the failure to provide extensive antitrust reforms, Dr. Traugott explained.

"ISMS' foremost concern is that patient care not suffer under reform," Dr. Traugott said. "We are a patient advocate organization. The patient's concern is also the physician's concern."

Since patients will ultimately make choices regarding their health care, any plan must urge patients to take responsibility for making wise health care decisions, Dr. Traugott said. Without such a provision, the reformed health system could become dangerously underfunded if patients overuse services.

"The issue of funding any proposal is multifaceted," Dr. Traugott continued. "Media estimates for creating the new federal bureaucracy alone have approached $29 billion. The prospect of global budget depletions, Medicare and Medicaid cuts, and government-controlled cost containment could critically compromise patient care."

DR. TRAUGOTT SAID the Society is also concerned about the extensive federal bureaucracy proposed by the president. As outlined in the president's proposal, the National Health Board would govern the new health care system by monitoring states' compliance with federal mandates, issuing health care budget regulations and updating the uniform benefits package. The proposed quality management program would develop quality improvement and accountability information and issue report cards on individual plan performances.

"Physicians worry that more levels of governmental bureaucracy could severely strain the physician-patient relationship," Dr. Traugott said. "And providers are specifically excluded from these governing bodies in the Clinton proposal."

Any proposal must include strong medical malpractice reform – especially caps on noneconomic damage awards, according to Dr. Traugott. "The malpractice reforms in the Clinton proposal are, on almost every count, inferior to what already exists in Illinois. Capping noneconomic losses is absolutely necessary to preserve access to care. Without a cap, awards will continue their wild ascent, and medicine will be unable to move forward under the strains of defensive medicine and the fear of malpractice suits."

In addition, antitrust protections for physicians must be expanded, said Dr. Traugott. "The antitrust reforms in the Clinton proposal must be more extensive to allow physicians freedom to negotiate on behalf of their patients."

ISMS WILL CONTINUE to work with physicians to keep Society concerns at the forefront of debate, Dr. Traugott said. But physician participation in outreach efforts must be broad-based, he added. Members can expect a series of mailings outlining the Society's positions on aspects of reform.

"Physicians have established a strong direct link to the public through their patients," Dr. Traugott said. "If physicians and patients become as knowledgeable as possible on this extremely important issue – one that will change the practice of medicine forever – all Illinoisans will benefit. We can then approach Congress with one strong voice for high-quality patient care and increased access." ■

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

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CONTRAINDICATIONS
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Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS
Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS
General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area ($mg/meter^2$). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS
Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE
There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

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JERY REPORTS MAY IMPOSE LIABILITY (PAGE 9)



Unlocking the secrets of Alzheimer's disease

PAGE 12

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • NOVEMBER 19 19

PHYSICIANS PLAY IMPORTANT ROLE IN DISABILITY DETERMINATIONS

PAGE 5

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Drug-related ER visits increase nationwide

SUBSTANCE ABUSE: The number of drug-addicted ER patients is on the rise. By Gina Kimmey

[SPRINGFIELD] The number of drug-related emergency room visits is rising in major cities nationwide, including Chicago, according to the results of a recent study conducted by the Drug Abuse Warning Network. Drug-related visits in Chicago ERs increased from 23,616 in 1990 to 30,532 in 1992, the study found. These results underscore an upward trend that began three years ago, said Jim Long, director of the Illinois Department of Alcoholism and Substance Abuse.

"We know that drug users become more susceptible to addiction's severe medical consequences over time," Long said, adding that cocaine- and heroin-related ER visits have increased. "There is a population of aging, chronic drug abusers who are now experiencing more problems and turning to emergency rooms for help."

Many patients seek care in hospital ERs because of drug-associated medical complications such as headaches and chest pains, rather than overdoses, said Michael F. McDermott, MD, director of observation medicine and an attending physician in Cook County Hospital's emergency department.

"The No. 1 reason for ER visits is chest pain, and I would say that about 10 percent of

(Continued on page 19)

Top five drug-related admissions in Illinois

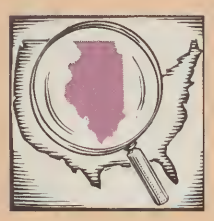
Alcohol	44,266
Cocaine	22,907
Narcotics	7,630
Marijuana	3,946
Amphetamines	244

Source: DASA, fiscal 1992

INSIDE

Access to OB and perinatal care expanded statewide

PAGE 4



DEPARTMENTS

News Briefs 2
Commentary 6
ISMIE Update.....9
IDPR Disciplines ..14
Classifieds 16



Matt Fergus

ISMS President Arthur R. Traugott, MD, explains the dangers of economic credentialing to members of the Illinois Health Facilities Planning Board.

Physicians blast economic credentialing practices

MEDICAL STAFFS: ISMS calls for due process and high-quality patient care. By Anna Brown

[CHICAGO] During an Oct. 26 public hearing conducted by the Illinois Health Facilities Planning Board, Illinois physicians said hospitals' economic credentialing practices could diminish quality of care for patients.

Testifying on behalf of ISMS, Society President Arthur R. Traugott, MD, told the planning board that in credentialing disputes, physicians are entitled to guarantees of due process. Physicians value their health care institutions and are committed to the survival of those institutions, he said. "But as a society, we run a huge risk if we allow our physicians, the people we rely upon to treat human ailments, to become nothing more than a part of someone's economic bottom line."

The Chicago hearing – and an earlier meeting held Oct. 7 in Springfield – are part of an Illinois General Assembly-directed study of economic credentialing conducted by the planning board. The board must report its findings to the legislature and the governor by Jan. 1, 1994. In April, the ISMS House of Delegates voted to seek legislative relief against economic credentialing practices.

Dr. Traugott noted that some physicians did not testify at the hearing, because they feared reprisals from hospitals that may practice economic credentialing. Only a few individuals presenting testimony at the four-hour hearing denied that

(Continued on page 19)

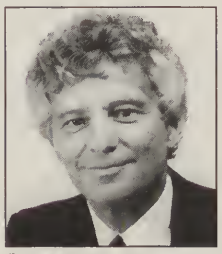
Medical educators consider reform's effect on physicians' specialty choices

REFORM: Medical school and residency program officials don't believe in forcing students into primary care. By Anna Brown

[CHICAGO] Following the Oct. 27 introduction of President Clinton's health system reform legislation in Congress, Illinois medical school deans and residency program directors are voicing concerns about government influence on specialty selection under the proposed shift toward primary care.

Several educators said they also have reservations about a proposal by the American Association of Medical Colleges and other organizations calling for half of all medical students to be trained in primary care. They noted, however, that health system reform and marketplace trends will force medical colleges to shift their focus toward primary care to remain effective teaching institutions.

"There will be a major change for many allopathic medical schools, because they train more specialists," said Leonard Mennen, DO, provost and dean of academic affairs for the Chicago College of Osteopathic Medicine in Downers Grove. "We have always emphasized primary care." The school is now placing greater emphasis on training students in ambulatory, rather than tertiary, settings, he said.



Dr. Mennen

"There's no question schools will try to encourage students to consider primary care, but I have a strong feeling that they can't necessarily make the horse drink," said Theodore Booden, PhD, dean of the University of Health Sciences/Chicago Medical School in North Chicago. "It's one thing to give students more exposure to primary care; it's another

(Continued on page 19)

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John McNulty

EVANSTON HOSPITAL medical residents Larry Sy, MD (right), and Ester Sy, MD (center), discuss practice opportunities with a health system representative from Knoxville, Tenn., during Career Opportunities Day for Internal Medicine on Sept. 18. About 120 residents attended the event, which was sponsored by ISMS' Resident Physicians Section, The Illinois Associates Council, the Illinois Society of Internal Medicine and the American College of Physicians, Illinois chapter.

Officials consider Illinois' public health future

REORGANIZATION: Public health leaders meet to discuss implementing Project Health. By Gina Kimmey

[BLOOMINGDALE] During the Illinois Public Health Association's annual meeting in September, state health officials met to discuss the progress of Project Health, a program designed to restructure and improve the administration of Illinois' public health services. Project Health was created to correct deficiencies in the public health system identified in a 1984 survey called the Roadmap Report. In that report, Illinois health leaders concluded that the system was not functioning at its "optimal level."

"We had taken our public health system for granted," said Illinois Department of Public Health Director John R. Lumpkin, MD. "We began shifting our priorities. We moved from a preventive care system to a casualty care system. We treated people after they were injured, after they became ill. We were spending our money in the wrong place, and that created a crisis in the public health system."

Administered by IDPH, the program has already established regulations that went into effect last July and are to be followed by local public health departments. "One of the biggest differences with the new regulations is that rather than set out 10 specific programs that every local health department must apply, this program sets out a methodology for doing local health planning, and public health becomes a part of that process," said Robert Murray, president-elect of the Illinois Association of Public Health Administrators.

Analyzing current public health programs and performing needs assessments help local health departments identify areas where services are lacking, Dr. Lumpkin said. "We had never had breast or cervical cancer as a major priority, but when we sat down and looked at the numbers, we realized this is a major cause of death for women that we haven't even addressed. So we placed it as a priority."

ISMS encouraged county medical societies to provide input to local health departments as they perform needs assessments and prioritize community health programs.

Although state Sen. Judy Baar Topinka (R-North Riverside) said she supports the concepts outlined in Project Health, she added that she doesn't believe the state has enough funding to implement new programs. "In terms of this particular project, we bring preventive health care right into people's backyards and neighborhoods. I think that is an awfully good idea. But you can't buy what you can't pay for."

Public health is still underfunded, understaffed and overburdened, according to Dr. Lumpkin. However, he said that the broad goals of Project Health can proceed by redistributing – rather than increasing – current state funding for public health programs. "We have a system that will not pay $10 for a measles vaccine but will pay an insurance company $110,000 to treat a child with measles encephalitis. For every dollar we spend on immunization, we save $10 in treatment. There is a tremendous amount of money to be saved if we focus the funds in the right place." ■

Traffic fatalities up

[SPRINGFIELD] The number of traffic fatalities reported in Illinois in September 1993 was 1.5 percent higher than the number reported in September 1992, according to the Illinois Department of Transportation. In addition, IDOT said its fatality figures from traffic accidents through September show a 21.3-percent increase over the same period last year.

The jump in fatalities was unexpected, since Illinois' traffic fatality rate had decreased for the past five years, said Chris Schwarberg, an IDOT spokesperson. "It's unusual to see an increase."

During September, 108 people were killed in 92 crashes, according to preliminary IDOT and state police statistics. In September 1992, there were 89 deaths. Overall, there have been 992 traffic-related deaths during 1993, compared with 977 deaths for the same period in 1992. The department noted that travel increased by 2 percent this year.

"The increase in the rate of travel is not directly proportional to the number of fatalities," Schwarberg said, explaining that it is difficult to determine why fatality rates rise or fall.

"We looked for a trend and found that there was an increase in the number of crashes in which there was more than one fatality," Schwarberg continued. For example, in September, one accident resulted in four deaths, and another caused seven deaths. In October, police reported another seven-death accident.

The two seven-death accidents occurred in southern Illinois – in West Frankfort and Carterville, Schwarberg said. Factors such as alcohol and speed – not failing to pay attention or poor road conditions – are often involved in high-fatality accidents, he added. ■

Health fairs focus on children and prevention

[CHICAGO] Only 25 percent of Chicago's preschool-age children are properly immunized, according to officials at Evangelical Health Systems' Bethany Hospital. Taking aim to improve that statistic, the hospital sponsored Well Child Health Fairs to promote prevention and health education to the people living in the West Side community Bethany serves.

This year, nearly 2,000 children attended the hospital's health fairs, receiving free immunizations and physical exams, lead poisoning and sickle cell anemia screenings, and vision and hearing tests. Bethany had sponsored one annual health fair since 1989, but a new Aetna Foundation grant the hospital received this year allowed for seven fairs to be scheduled in 1993, said a hospital spokesperson.

"I've seen so many children in the community who have received no immunizations or whose immunizations were incomplete. It is a very fragmented kind of care," said Mohammad Y. Chaudary, MD, chairman of the hospital's department of pediatrics and a health fair participant. "We decided to go out to the churches and the schools, and get in touch with the parents so that they realize the importance of prevention."

The health fairs offered eight stations: registration; immunization record review; height, weight and blood pressure workups; physical examinations; immunizations; laboratory tests; vision and hearing screenings; and discharge. At the discharge station, parents learned which immunizations their child still needed, and they were encouraged to schedule immunizations and checkups. During the fairs, adults were offered free education materials and diabetes and hypertension screenings.

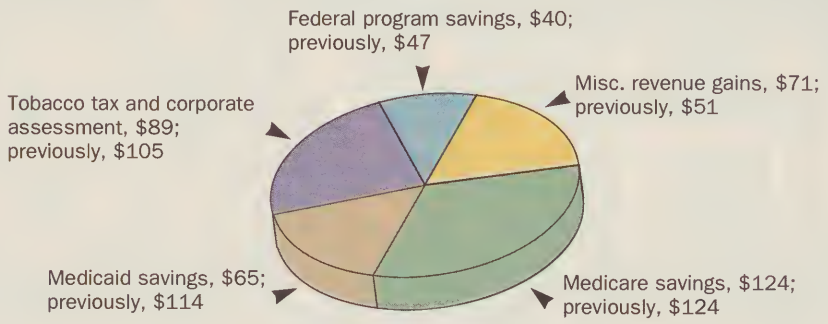
"The most important aspect of the health fairs is the education and community outreach," said Crystal Mobley, manager of Bethany's Family Health Center and health fair organizer. "In addition to immunizations provided at the health fairs, we schedule children for shots they need. We also help educate parents on how important these immunizations are to the long-term health of their children."

"We still have many children who are not yet immunized; there are many children we haven't yet reached," said Dr. Chaudary. "But the response to the fairs has been excellent. We are making a real difference in the community." ■

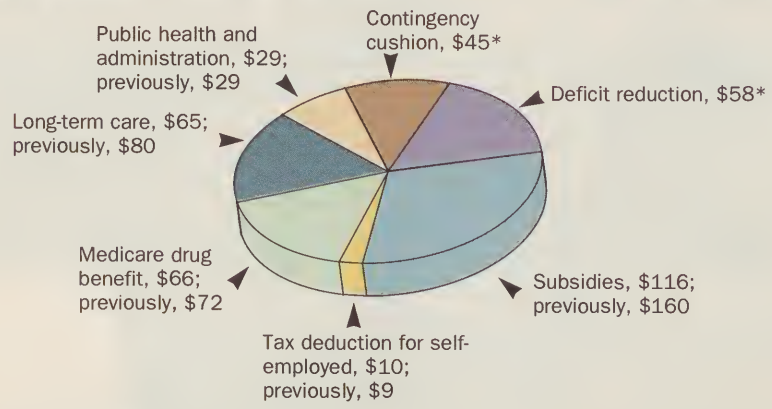
PHYSICIAN FACTS

President Clinton's original proposal vs. bill submitted to Congress

Source of funds — **Total $389**
(Figures in billions of dollars for 1995-2000) — **Previous total $441**



Use of funds — **Total $389**
(Figures in billions of dollars for 1995-2000) — **Previous total $350**



Source: The White House
*Figures unpublished in original proposal

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ISMS conducts physician speaker training programs

[CHICAGO] ISMS is sponsoring a series of physician spokesperson training seminars in four downstate communities. The programs are one component of the Society's "Health Reform: Taking Charge of Change" campaign aimed at educating physicians and the public about health system reform.

Each downstate training program is open to all ISMS member physicians and will focus on helping doctors communicate key messages about reform to their patients and the media. The first 3½-hour training session is scheduled for Dec. 2 at the Springfield Renaissance Hotel at 6 p.m. The deadline for registration is Nov. 29.

The other three programs will be held in Rockford at the Winnebago County Medical Society offices on Dec. 13, in Collinsville at the Holiday Inn on Dec. 14 and in Peoria at the Holiday Inn-Brandywine on Dec. 15. All programs begin at 6 p.m.; registration deadlines are three days prior to the event.

Programs are free, but preregistration is required. Dinner will be served. To sign up for a session or receive more information, physicians may contact the ISMS public relations and field services department at (312) 782-1654 or (800) 782-ISMS, ext. 1150. ■

Project Success offers health and social services

[SPRINGFIELD] Thirty-three Illinois communities have been selected this year to participate in Project Success, a pioneering state effort that provides school-based services to children who have family and health problems that impede their learning.

Project Success targets Illinois schools in which at least 20 percent of the students are economically disadvantaged. Through the program, people from various government agencies discuss community problems and brainstorm ways to provide necessary services to families.

Gov. Jim Edgar launched Project Success earlier this year in his role as chairman of the Education Commission of the States. The program was developed by Lt. Gov. Bob Kustra and a committee of teachers, school administrators, community-service providers and the directors of six state social service agencies, as well as representatives from the State Board of Education, private social service agencies and advocacy organizations. In 1992, pilot projects were instituted in Chicago's North Lawndale and Albany Park communities, and in Freeport, Decatur, Waukegan and Joppa. These projects will continue to receive state support in 1993.

Edgar said he would like to see the program spread to other states. "Our underlying goal is to provide access to human and social services for children and families to insure that all Illinois children come to school ready to learn," said Lori Williams, project specialist in the governor's office. "For example, in our first year, many of our sites had immunization clinics prior to the beginning of school, so that all the children could be in school the first day." ■

Illinois AIDS organizations receive grants

[SPRINGFIELD] The Ryan White AIDS Victims Assistance Fund has distributed $96,000 to six Illinois organizations that provide housing to individuals who have HIV and AIDS, announced Illinois Department of Public Health Director John R. Lumpkin, MD.

"Many of those infected with HIV or who have AIDS have lost their jobs because they are too ill to work. In turn, they have lost a place to call home because they couldn't afford housing," said Dr. Lumpkin. "Through the generosity of nearly 17,000 taxpayers in Illinois, housing is being made available for these people who have nowhere else to turn." Taxpayers donated the $96,000 through their 1991 state income tax returns.

The grants were awarded based on several criteria, including the organizational experience, the practicality of the projects and the ability to provide services to women, children, minorities, substance abusers and hemophiliacs.

The agencies receiving grants are the Prairie AIDS Foundation in Urbana, Friends of Persons with AIDS in Peoria, Community Response in Oak Park, the Catholic Urban League in East St. Louis, the Open Door Clinic in Elgin and Chicago Health Outreach.

The Ryan White Victims Assistance Fund will no longer appear on Illinois tax forms, because it failed to reach the required $100,000 threshold. Instead, the Ryan White Pediatric and Adult AIDS Fund will be listed as a voluntary contribution option on 1993 state tax returns. Donations will fund care and counseling for AIDS patients. ■

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REPORT FOR *Illinois Physicians*

HEALTH CARE REFORM

THE RESPONSE OF BLUE CROSS AND BLUE SHIELD OF ILLINOIS

Health Care Reform is indeed one of the most important issues of our time in the United States. Blue Cross and Blue Shield of Illinois (BCBSI) would like to use this regular report as a means by which we can inform the members of the Illinois State Medical Society about BCBSI's position on various health care reform proposals put forth by President Clinton's administration and by others. In this issue, we will indicate some of the most important of BCBSI's positions, and in future communications we will go into more detail and/or discuss our stand on other proposals.

There is no question that health care costs in the United States, now estimated to be $938 billion per year, or 13.6% of the Gross National Product, are creating a major economic problem for our entire society, and are simply unacceptable. Furthermore, a significant additional social problem has been created by the fact that 37 million people are without any health insurance, and perhaps 30 million additional people have inadequate health insurance, in spite of the U.S.A.'s enormous health care expenditures. These unresolved problems have resulted in the present sweeping proposals for health care reform legislation with which we are all faced today.

BCBSI **supports** the following proposals:

- Universal Health Insurance
- Portable Health Insurance (i.e. insurance that stays with an individual throughout his/her lifetime, regardless of employment or health status)
- Employer Based Insurance
- Comprehensive Basic Benefits Package
- Health Insurance Reform
  - No denials of coverage because of health status.
  - No pre-existing condition waiting period.
  - Community Rating, rather than experience rating.
- Malpractice Tort Reform
- Affordability through Competition and Appropriate Utilization Management

BCBSI **opposes** the following proposals:

- Establishment of Health Alliances - BCBSI believes health alliances will create a huge new bureaucracy which will duplicate functions already being performed by health plans and insurers, and therefore will increase, and not decrease, administrative costs.
- Global Budgets and Premium Caps - BCBSI opposes global budgets and premium caps because they are price controls (which never work), because they will undermine real price competition, because they will be driven by federal budget priorities, and because they will impair the ability of health plans to develop the new data systems needed to achieve cost containment and improved health care outcomes.

More on these important topics will follow in the coming months.

(Issue: 11/19/93 - ALW)

Access to OB and perinatal care expanded statewide

SERVICES: The state's network helps high-risk pregnant women and their infants obtain quality care. By Gina Kimmey

[SPRINGFIELD] Through a statewide system of 10 regional centers, the Illinois Department of Public Health's obstetric and neonatal referral network aims to improve the health of mothers and their babies, said Bob Sabitch, program administrator. The centers coordinate perinatal care delivery in their area by assuring that patients have equal access to high-quality services, regardless of where they live in Illinois, Sabitch said. There are six centers in metropolitan Chicago and centers in Rockford, Peoria, Springfield and St. Louis.

"The referral system benefits high-risk mothers and babies by allowing them to receive the appropriate level of care, in the appropriate setting," said Tim C. Miller, MD, director of neonatology at St. Francis Medical Center, Peoria's network center.

"The basic functions [of the centers] are coordinating care, providing educational outreach for providers and transportation services for patients being referred to other areas for treatment, and monitoring, evaluating and following up on the care of such patients," said Sabitch.

All Illinois hospitals are required to participate in the $4-million-per-year program through affiliation agreements with the network center in their area, Sabitch said. Peoria's St. Francis, for example, serves as a referral center for 29 hospitals. Of the region's annual 16,000 to 18,000 births, St. Francis provides care for more than 300 high-risk mothers and 650 to 700 high-risk infants, Dr. Miller said.

The framework for the current referral system was established in 1942, when Illinois became one of the first states to use federal grant money to develop premature-infant stations, Dr. Miller said. St. Francis and St. John's Hospital in Springfield were the first two stations established outside Cook County, he noted. In 1969, the system was expanded to include all sick babies, not just premature infants. Then in 1975, the referral network for high-risk mothers was incorporated, Dr. Miller added.

THE NETWORK CLASSIFIES Illinois hospitals that provide perinatal care as level I, II or III facilities, depending on the intensity of maternal and neonatal care they offer. Level I facilities provide services for women who have uncomplicated or minimally complicated pregnancies and births and their infants, Sabitch said.

According to the perinatal care guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, level I facilities must establish a program to identify high-risk mothers and neonates. These hospitals must provide consultation, referral and transfer services to high-risk patients when necessary. Level I facilities are also required to manage unexpected emergencies or complications until transfer to a higher-level hospital can be arranged.

"Risk assessment, combined with referral to risk-appropriate services, is central to regionalization," Sabitch explained. "Any pregnant woman who is identified as being at high risk for complications is given access to a specialist for consultation. Based on that evaluation, the patient can be moved to a more intensive center for observation and/or delivery."

The majority of deliveries occur in level II facilities, which provide most of the services in urban and suburban areas, Sabitch said. Level II facilities are able to provide an array of services, because their staffs are skilled in multidisciplinary medicine and nursing.

Patients who experience rare or unusual problems and complications are referred to level III facilities, Sabitch said. Those hospitals have the most sophisticated resources, such as personnel, equipment, expertise and experience, he noted. The network's 10 centers are all level III facilities, and are responsible for providing intensive-care-level services on a 24-hour basis.

"We want to identify women at risk for early delivery or complications," said Sabitch. "Then [we will] link them to the appropriate specialist, who can evaluate their condition and determine the need-appropriateness of the situation, and provide transportation to the appropriate facility to provide the best care available."

Offering this type of integrated care may be more difficult, however, as HMOs and managed care become more prevalent, because they usually don't allow patient referrals out of their systems, Dr. Miller said. "Whether or not it will impact the quality of services is still not known. But it will definitely influence the referral and network patterns [with] which the physicians and patients in this area have become comfortable." ■



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Physicians play important role in disability determinations

RECORDS: A state agency is requesting physician cooperation to speed up approvals of patient benefits. By Anna Brown

[SPRINGFIELD] Physicians should not ignore the Medical Evidence of Record forms they receive from the Illinois Department of Rehabilitation Services' Bureau of Disability Determination Services. The information physicians provide on those forms is necessary for patients to receive disability benefits from the federal Social Security Administration, said Dan Rivero, the bureau's medical relations supervisor.

Receiving the MER forms is "something every treating physician faces," Rivero said. "We have to send them. It's the law. We're legally obliged."

Last year, the bureau reviewed 130,000 benefit applications from individuals who were no longer able to work, Rivero said, adding that 170,000 have already been received this year. An MER form is sent to the treating physician for each patient, he said. However, if doctors fail to complete the form or forward a copy of the applicants' medical records to the bureau, patients must undergo another examination by a consulting physician before their application can proceed, Rivero explained.

The MER request explains the nature of the medical information the physician should supply, the amount the bureau will pay for the report and the name of a staff contact who can answer physicians' questions, said Edward G. Ference, MD, the bureau's chief medical consultant. After the bureau receives a completed MER, a physician consultant or adjudicator may call the treating physician for clarification or more information.

"Generally, physicians are very cooperative," said one of the program's consultant physicians. "We have a plea for physicians to supply the requested information. Sometimes physicians hesitate to provide the information because they are busy, but it's in their patients' best interest. It takes so little effort; they only need to supply what they know."

To be considered disabled under Social Security law, adults must have a physical or mental impairment or a combination of impairments that prevents them from "doing any substantial gainful work," according to a bureau fact sheet. For benefits to be approved, the impairment must last at least a year or result in death. Children can receive disability benefits if they have a "medically determinable physical or mental impairment of comparable severity to that which would disable an adult," according to the fact sheet. That disability must also be expected to last a year or result in death.

The Social Security disability program is 100-percent federally funded, said Joan Fafoglia, deputy director of the program. All 50 states participate in the program, and the disability criteria are identical across the country.

THE APPLICANTS' TREATING physicians often provide the bureau with enough information to support a claim. Some individuals, however, may not have a personal physician, or the physician may fail to supply adequate information to help determine whether disability benefits should be allowed or denied, Fafoglia said. Those cases are referred to consultative examination panelists.

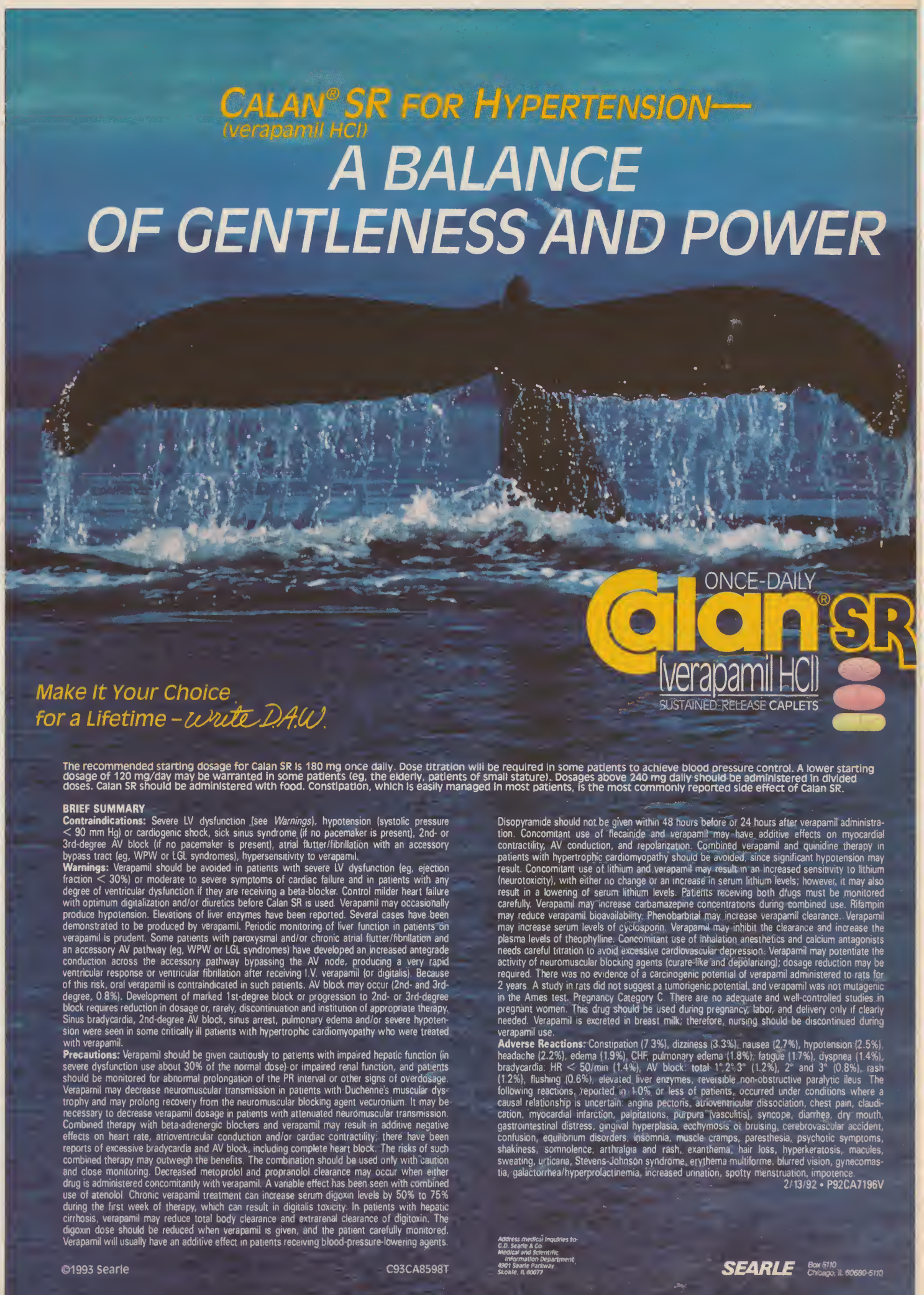
More than 1,200 physicians statewide serve as CE panelists, Dr. Ference said. In addition, the bureau employs physicians part-time to review applications in conjunction with trained adjudicators. Although these physicians do not examine patients, they ultimately determine whether the disability benefit will be allowed or denied, he explained.

"CE physicians are never held personally accountable for an allowance or a denial," Fafoglia said, noting that a combination of evidence, including CE panelists' reports, is used to make determinations. Also, CE physicians do not treat the referred patients they examine.

Physicians are reimbursed based on their specialty and the specific tests performed during the exams, as well as for the reports they prepare, Fafoglia said. CE physicians also determine the number of referrals they will accept.

Currently, the program needs pediatricians and psychiatrists to serve as consultant physicians, Dr. Ference said. In the past few years, applications for disability insurance have increased significantly because drug and alcohol abuse is now considered a disability. The criteria for disability benefits for children have also been expanded, causing the number of child applicants to soar, he said.

Physicians interested in becoming CE panelists should send a curriculum vitae to the Chief Medical Consultant, Bureau of Disability Determination Services, Illinois Department of Rehabilitation Services, P.O. Box 19250, Springfield, IL 62794-9250. Physicians may fax MERs to the bureau at (800) 852-5114. ■



Illinois Medicine

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EDITORIAL

The battle for tort reform continues

In April 1992, James V. Vest, MD, a Belleville physician, was thrown in jail. No malpractice suit had been filed. The plaintiff's lawyer had not even obtained the required certificate of merit. Yet when Dr. Vest exercised his legal rights during a deposition and refused to answer a question about his treatment of a patient, he was jailed for seven hours.

To prevent that kind of injustice from ever happening again, physicians need protection. To help provide it, an organized effort by the Illinois Civil Justice League is under way. Along with the Southwestern Illinois Industrial Association, the league is holding a two-hour forum to explore how consumers and the business and medical communities can work together to enact changes that restore fairness in the legal system.

ISMS recently furthered its support of tort reform by joining the Illinois Civil Justice League. That step has also been taken by 89 other Illinois groups and businesses, including Ameritech Corp., Deere & Co., the Illinois Manufacturers' Association, the Illinois State Chamber of Commerce, Quaker Oats Co. and Shell Oil Co.

According to the league, frivolous suits result in higher prices for consumer goods, health care and insurance, as well as increased taxes. It seems pointless to pursue state or national health system reform that fails to address the out-of-control judicial system contributing to escalating costs.

The tort reform issue of primary importance to ISMS is capping awards for noneconomic damages in civil suits, including malpractice cases. That priority dovetails with the league's goals. In fact, its focus groups and related research have shown that caps rank No. 1 among its corporate members as the most effective way to contain the costs of the legal system.

As you'll recall, during the past legislative session, a bill that would have set a cap at $250,000 passed the Illinois Senate but died in the House. Although no legislation was passed, the progress of the bill provided an opportunity for ISMS leaders to testify on the urgent need for caps and allowed legislators to hear a perspective besides that of the plaintiff bar. It was a start, but there's more work to be done.

ISMS and the Illinois Civil Justice League will continue working on the issue. The liability reform forum is scheduled for 9 a.m. on Dec. 2 at the Holiday Inn in Collinsville. Area physicians are encouraged to attend and keep up the fight for meaningful tort reform.

PRESIDENT'S LETTER

Increasing our impact through IMPAC

By Arthur R. Traugott, MD



By helping selected candidates, you are ultimately helping shape the legislation and regulation that affect you and your patients every day.

The 1992 elections brought many new Illinois legislators to the General Assembly and U.S. Congress, and next year's elections will bring even more. They, along with the incumbents, are in a position to influence changes on such critical issues as medical malpractice and health system reform. The upcoming primaries and next year's elections present even greater opportunities to help friends of medicine.

Especially now, with health system reform imminent, we must continue to help the voice of organized medicine be heard in Springfield and Washington. As physicians, we are uniquely qualified to act as patient advocates, and we have a special obligation to ensure that the political and governmental processes work to maintain quality health care.

By now, you have received your annual ISMS dues bill, which includes the option of contributing to IMPAC – the Illinois State Medical Society Political Action Committee. IMPAC is a voluntary, not-for-profit group composed of physicians and their spouses. Contributors support those candidates for public office who share the views of the medical profession on important issues.

Here's how IMPAC works. Its affairs are governed by the IMPAC Council, which consists of 30 individuals elected from membership. Council members serve as volunteers without compensation for three-year terms.

IMPAC gives 100 percent of contributions received to those candidates recommended by IMPAC members in local districts. Then, the council makes the final determinations about the distribution and size of the contributions based on the candidates' particular needs in a race.

When it comes to helping medicine's supporters get elected, IMPAC has been very successful. But the competition is fierce and gaining momentum. For example, PACs for trial lawyers and self-proclaimed consumer advocates are aggressively soliciting members and are strengthening their presence in the political arena.

In addition, our friends, like U.S. Rep. Robert Michel, eventually retire, and we need to continuously work at identifying potential candidates who understand our views. Look at what's happening in Washington. Nonphysician groups are lobbying the president and Congress with claims that broadening their scopes of practice will lower health care costs and improve access. In reality, expanded scopes of practice of health care provider groups that did not attend medical school represent a step backward, not forward, in promoting quality health care.

I believe that American patients are entitled to receive the benefits of our medical school training and licensing by having their physicians diagnose illness, prescribe medicine and perform surgery. We all support responsible reforms to improve access and lower costs in our current health care system. But we need state and federal legislators who have the insight to understand our concerns and can distinguish when actions could compromise patient care.

Consider the 1992 election year and the 88th General Assembly session. IMPAC was successful in building a medical majority in the Illinois Senate, which led to passage of a bill calling for caps on noneconomic damages in medical malpractice awards. Now that same challenge lies ahead in the Illinois House, where very close to a majority of state representatives support our tort reform efforts. And in 1994, we will also be faced with the gubernatorial race.

You stand to directly benefit from your contributions to IMPAC. By helping selected candidates, you are ultimately helping shape the legislation and regulation that affect you and your patients every day.

Currently, only two out of five ISMS members contribute to IMPAC. If we want to continue to have an impact in the political arena, we must increase that number now.



"Mr. Allison and his second opinion are here to see you."

GUEST EDITORIAL

A different road to reform

By U.S. Rep. Robert H. Michel

The following are House Republican Leader Robert Michel's remarks in response to President Clinton's health system reform legislation:

Mr. President, let me first congratulate you on carrying out your health care proposal in time-honored medical fashion: You have given your bill a new examination and diagnosis, and you have now come to Congress for a second opinion. It is fitting that our meeting should take place in this great room, which for so many years was the chamber of the House of Representatives. It is a place that over the years has seen so much debate and discussion about the best course for our nation.

The long-awaited presentation of your health care reform bill today is just the beginning of a long, tortuous process that must wind its way through the Congress. The debate is destined to change the health care system in this country – and the very nature of our society. And so, as this process begins, we should be clear as to what the debate will be about.

There are substantive and profound policy differences between those who support the concepts at the heart of your bill, and those of us – like myself – who see another, different road to health care reform. Yes, there are some areas on which there is agreement.

I have already stated my desire to have those points of agreement acted on immediately for the American people – and the offer still stands. But the real differences cannot be glossed over.

The debate that begins now will be about nothing less than conflicting visions of what America means – not just about health care reform itself, but about

- The role of government in our society;
- The threat of further expanding bureaucracies;
- The time-honored nature of the doctor-patient relationship;
- Taxes, fees and mandates. Whether our health care system is essentially to retain the private-sector character that has made it great or whether we will embark on an uncharted course of government-run medicine.

So I say, let the most eloquent and knowledgeable champions of the competing visions tell the American people – in open debate – what they believe is important.

Then out of the debate can come a health care vision that is best for all Americans, if only we, their elected officials, have the courage and fortitude to ask the tough questions and give the honest answers.

Rep. Michel is a Republican congressman from Peoria.

ISMS speaks on health system reform

Within the last month, ISMS leaders have shared the Society's perspective on health system reform with groups throughout the state. The following are highlights:

Health Reform
Taking Charge Of Change

Oct. 18 – ISMS President Arthur R. Traugott, MD, addressed the Adams County Medical Society.

Oct. 20 – Dr. Traugott spoke at a Coles-Cumberland County Medical Society meeting.

Oct. 25 – Dr. Traugott attended an Evanston town hall meeting.

Oct. 27 – ISMS First Vice President Raymond E. Hoffmann, MD, was a guest speaker at a University of Illinois Hospital medical staff meeting in Chicago.

Nov. 2 – Dr. Traugott addressed the Madison County Medical Society meeting.

ISMS President-elect Alan M. Roman, MD, spoke to Northwestern University Medical School student members of the Alpha Omega Alpha honorary society.

Nov. 4 – Dr. Traugott attended the Southern Illinois Medical Association meeting in Belleville.

Nov. 14 – Dr. Roman was a panelist at a town hall meeting on health system reform sponsored by state Rep. Carolyn Krause (R-Mt. Prospect).

Nov. 16 – Dr. Traugott spoke to the LaGrange Schools' special education department at Lyons Township High School.

GUEST EDITORIAL

A crisis in health care reform?

By James P. Ahstrom Jr., MD

Is there a health care crisis? According to *Webster's* dictionary, a crisis is a turning point for better or worse, a point in time when a decision is made about whether an affair or course of action will proceed, be modified or be terminated.

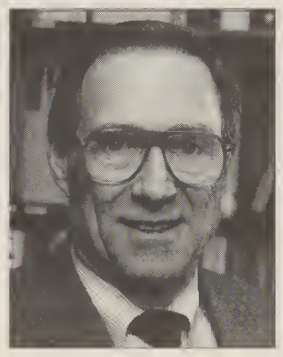
I don't believe we are now confronted with such a narrow period during which decisions must be made. However, we are continually bombarded by criticism about health care delivery, complaints about costs and allegations of poor access to medical care. This extended onslaught cannot qualify as a crisis; instead, it is a campaign for change in health care delivery. The desired change is reduced expenditures.

There is much hue and cry about the 37 million citizens who are uninsured. That number includes many who are temporarily unemployed and therefore not covered, and those who elect to be uninsured, such as young people age 18 to 22 who do not wish to pay health insurance premiums. Eighty-five percent of the 37 million uninsured are employed. I have heard that the hard-core uninsured really number 7 million or 8 million, which constitutes 3.2 percent of our population.

If people are uninsured, are they deprived of access to medical care? We are led to believe they are. But if they have a problem, they simply go to an emergency room and receive probably the best care available in that area. If they don't like the first emergency room, they go to a different one – and possibly a third. They have access in no uncertain terms, and probably better access than if they were limited to family physicians or doctors under the HMO gun to treat as few patients as possible. So there is access.

The reason the administration wants to cut health expenditures is not that Mr. Clinton feels sorry for those who pay high health insurance premiums or that he really wants to economize on health care. He wants to use health care savings to offset the deficit. Whether that is possible is indeed questionable. Estimates vary, but the United States spends anywhere from 11 percent to 14 percent of its gross domestic product on health care. The United States spends more than that on recreational activities. Some say Canada spends 8.5 percent of its GDP on health care, but one has to take into account the oppressive taxes Canadians pay to fund this slow, often second-rate medical care.

The U.S. government's share of health expenditures was 10 percent in 1965, 27 percent in 1975 and 30 percent in 1986. And Medicare and Medicaid make up only 29 percent of the country's total health care expenditures. Yet everything we hear would lead us to believe that government is paying the entire health care bill.



Dr. Ahstrom *is an orthopedic surgeon from Downers Grove.*

Americans want the very best when it comes to treatment for their illnesses or injuries. In fact, we demand it and expect it – in a hurry. In other countries, the very best is not available to everyone. Patients who need surgery often face delays of several months. Americans would not accept this – would we? If one demands the best, it must be paid for.

There is nothing wrong with paying for what you get or being paid for what you do. Under managed care, money – in the form of premiums – is collected from patients for care they might need. If treatment costs more than the amount collected, there is great complaining. If patients need less care, the HMO is a great success. HMOs come out ahead only by forcing hospitals and doctors to work at discount rates. Could you force your grocer to give you a 15-percent to 20-percent discount? Of course not! HMOs – tools the Clinton administration wants to use to control expenditures – are really middlemen.

It is difficult to see how putting entities between doctors and patients can make care any less expensive than if patients went directly to their doctors. The Clinton plan's proposed health care alliances are yet more middlemen who will collect premiums and then arrange HMO coverage for patients. Then patients will be permitted to see a doctor. That lengthens the ladder of bureaucracy. Most people agree that wasteful expense is bad. However, government regulation has never proved to be the remedy.

The administration plans to cap reimbursement – especially to specialists. In what other profession or business is payment limited by law and liability unlimited? If such a system is enacted, patients will continue to receive care, but it may become minimal, and the quality will eventually suffer.

It is easy to criticize medical professionals. By nature, they listen, they want to improve and they cooperate. By training and instinct, they want to get the job done and will do the best they can for their patients. It is a personal challenge and a matter of pride. However, this mind-set could be eroded. One must have proper incentive to keep pushing ahead and improving day after day, week after week, year after year.

Bashing the profession through continual regulation and limitations will ultimately diminish quality. Conscientious doctors will do the best they can, but even they will reach their limits. If this continues, who will be willing to carry on the noble goals of medicine? Who will be willing to do the research, the study and the hard work to ensure the profession remains vital and self-sustaining, and provides the highest possible level of service? For the good of the nation, medicine must be encouraged, not subjected to incessant bombardment, restrictions and regulations.

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• Large check processing for multiple patients?	Yes	No	No
• All modules, (appointment scheduling, electronic claims, etc.) included for one low price?	Yes	No	No
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ISMIE Update

It is personal
PAGE 10

Illinois Civil Justice League tort reform hearing
PAGE 6

Data bank self-query reports may impose liability

Physicians should ensure that confidentiality provisions are maintained before passing reports they requested to other entities. By Janice Rosenberg

National and state medical societies are considering how physicians should respond to requests that they "self-query" the National Practitioner Data Bank. Physicians receive those requests from PPOs and other managed care plans, as well as from some medical liability insurers, none of which are authorized to query the data bank themselves.

Initiated in September 1990, the data bank was created under the federal Health Care Quality Improvement Act of 1986 to serve as a national repository for information regarding licensure, clinical privilege and society membership actions related to physicians' professional conduct and competence. The data bank also collects information concerning medical malpractice claims.

The AMA and ISMS have maintained that a national data bank is unnecessary. "States already had their own information in data banks," said William E. Kobler, MD, chairman of the ISMS Hospital Medical Staff Section Governing Council. "All we had to do was set up some kind of communication between the states, but the [federal] government thought it could do it better."

It is unclear whether the confidentiality guarantee covers reports provided to unauthorized entities.

Under the Act, information contained in the data bank is confidential and can be released to and used by only authorized health care entities. As defined by federal law, those entities provide health care services and engage in formal peer review activities. Hospitals are required to query the data bank whenever a physician requests medical staff membership or clinical privileges and at least once every two years for each person on their medical staff.

State licensing entities, HMOs and group medical practices hiring physicians may also query the data bank. However, the public, PPOs and other managed care plans do not have access to data bank files.

IN RECENT MONTHS, entities that lack authority to query the data bank have tried to obtain physicians' files by asking the doctors to request their own files and send them to the credentialing entity. "The legal environment is becoming such that some

(Continued on page 11)

AMA sample letter

Dear _____:

You have requested that I "self-query" the National Practitioner Data Bank (data bank) and provide a copy of my data bank report to you. You are no doubt aware that the information contained in the data bank is confidential and is intended for use only by those entities that are "authorized" under the federal Health Care Quality Improvement Act of 1986, the law that created the data bank. The federal law defines authorized entities as health care entities that (1) provide health care service, and (2) engage in formal peer review.

It is presently unclear whether the confidentiality provisions of the federal law and the accompanying regulations continue to apply to data bank reports that are disseminated by a physician to an unauthorized entity. Because of the highly sensitive nature of the information contained in the data bank, I will require, prior to submitting any information to you, written documentation from your organization that responds to each and every one of the following issues:

1. That the requirement that I self-query the data bank and disclose the information to you is in compliance with the intent and statutory protections of the Health Care Quality Improvement Act of 1986.
2. That the information disclosed to you will be protected from further disclosure under the relevant state peer review immunity statute(s).
3. That the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s).
4. That your organization will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act.

Unless your organization can comply with these requests, please be advised that I cannot submit any information received by the data bank to you.

Very truly yours,

MALPRACTICE ROUNDUP

Failure to corroborate

A Florida appellate court sanctioned a malpractice insurer for failing to corroborate the reasons it denied a plaintiff's claim.

According to the *Malpractice Reporter*, the plaintiff had informed the insurer in writing that she intended to file a malpractice claim against one of its physician-insureds. The plaintiff also provided the company with an affidavit of merit from a board-certified gastroenterologist and internist. The affidavit stated that there were reasonable grounds to believe that the defendant-physician was negligent and that his negligence resulted in the patient's injury. It also stated that the defendant-physician delivered care below acceptable medical standards. The affidavit also outlined the documents reviewed by the expert physician and the grounds for the claim.

The physician's insurer denied the claim, attaching a "corroborating" affidavit from another medical expert stating there was "reasonable ground for lack of negligent injury." The insurer's affidavit did not indicate the doctor's area of practice, the documents he had reviewed or the aspect of the alleged negligence he was refuting. The plaintiff responded by filing a malpractice suit and seeking sanctions against the insurer for denying her claim without providing sufficient reasons for the decision.

The trial judge found the insurer's response failed to comply with Florida's "reasonable investigation" requirements. The judge said the affidavit did not identify the medical records reviewed, the factual basis of the legal conclusion, the expert's professional qualifications or the location of the expert's practice. The trial court's decision was affirmed on appeal. ■

Disclosure of incident report

As reported in *Hospital Risk Management*, the manufacturer of a neuromuscular stimulator sued an Indiana hospital, claiming a patient's injuries were caused by negligence, not a defective device.

A patient had sued the manufacturer, alleging that a stimulator used in physical therapy was defective and unreasonably dangerous because it had shocked his leg. The patient did not allege that the injury was caused by negligent care delivered by the hospital's physical therapist, who had filed a report with the hospital's quality assurance department after the incident. The manufacturer called for the hospital to produce the incident report, and a district court granted that motion.

The hospital appealed, claiming the report was privileged because it had been filed with the hospital's quality assurance department, which qualified as a peer review committee. The manufacturer argued that the report only documented a hospital incident and therefore did not constitute communication with a peer review committee. The Indiana appeals court supported the hospital's claim, reversing the trial court decision and prohibiting disclosure of the incident report. ■

It *is* personal

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Dear Ben:

You and I had been friends for years. Although you are an attorney and I a physician, our relationship had been personal, not professional. I was interested, therefore, when an opportunity arose to watch you work. More than one year ago, you were one of a team of lawyers representing the plaintiff in a medical malpractice lawsuit. The plaintiff was a man whose wife died within hours of being admitted to the hospital. He alleged that care by the admitting physician had been negligent.

I decided to watch the trial for all of its 40 hours. I felt the pain of the treating physicians as they testified. I heard the jury announce its verdict in favor of the plaintiff. The experience confirmed for me that although you and I live in the same city, we live in different worlds.

Let's go back. You know well the facts of the case. The defendant was one of several physicians caring for the patient. The other defendants had settled before trial for large amounts. The remaining defendant and her insurance company chose to defend the case because they were convinced she acted appropriately. After watching the trial, I believe they were right. She provided good care. However, a jury trial is a difficult place to explain the subtleties of diagnosis and roles of different medical providers. It is also a terrible place to be the last defendant when others have already settled, whether or not you did anything wrong.

I learned a great deal during the trial. I learned about the cold calculation of an attorney assessing the "jury appeal" of a case. I learned how you and your colleagues communicate on several levels at once, signaling contempt by body language and tone of voice. These never appear in the transcript of a trial, but seem at least as influential to the outcome as the words that do.

I learned how fascinating your world can be, Ben. I found myself plotting strategy to attack from strength and to defend weaknesses. I enjoyed the challenge to use language precisely, to present logic clearly. I felt the exhilaration of the fight. However, having visited the world in which you work, I am repelled by it.

Plaintiffs and defendants appear as incidental props on the field where you and the opposing attorney share your fun.

As a physician, I hold at least three values that are different from yours. First, I believe in science as an approach to truth. Although we may not always be able to label a patient's problem accurately or measure it precisely, physicians believe there is, nonetheless, a physical truth about illness. For example, we believe that some people develop appendicitis. Even if we called it a headache or conversion symptom, the physical reality of the inflamed appendix would remain. Physicians seek to discover scientific truth and act on it to the benefit of patients.

As advocates, attorneys do not seek objective truth. Rather, you deal in persuasion, in applying meaning to ambiguous data. The goal of litigation is to dispose of disputes, not find truth in the scientific sense. Truth is what the jury says it is. You win if you persuade jurors of your version. The trial demonstrated clearly that jurors do not understand concepts that professionals take years to acquire. Defendants in medical malpractice cases are not tried before a jury of their peers. You profit from this.

The second difference concerns pain. Medical ethics dating back to at least Hippocratic teaching emphasizes that the physician's role is to help, not hurt, our patients. Despite this, physicians sometimes deliberately hurt people. We perform painful tests and procedures. We prescribe distressing medications. We sometimes hurt people unintentionally, out of misdiagnosis, improper therapy or complications of appropriate treatment. This is inevitable in medicine. It is rarely true malpractice, and our objective should always be to do more good than harm.

As a plaintiff's attorney, you seek to "even the score." For your client to win, the other side must lose. Thus, you make a living off creating winners and losers. You, by definition, must hurt someone to serve your client and feed your family.

The third difference is that when I go home from work, I do not deliberately act in a way contrary to my role as a physician. To nurture your family, care for your neighbor or be a friend, you must act contrary to your role in the courtroom. Physicians are repeatedly amazed at how lawyers fight viciously in front of the jury and later join in camaraderie and fellowship. The game is what counts, the test of intellect, of wills. You have been taught not to take it personally. To an observer, plaintiffs and defendants appear as incidental props on the field where you and the opposing attorney share your fun.

I learned some things about myself, too, Ben. I learned that I have limits to my ability to understand, accept and forgive. My revulsion about what happened is as intense today as it was one year ago. I confess my failure to reconcile my world with yours. I have not overcome my emotional response with reason.

However, I also learned what I cherish. I value personal caring, the scientific approach to finding truth, and the use of knowledge and power to enhance life. Despite the risk, I choose to remain vulnerable, to stay personally invested in my patients. I must do so to provide the best care of which I am capable.

Ironically, even telling you these things represents risk. Having watched the process, I assume you will use my thoughts and feelings to refine your attack on my colleagues or me in the future. I am already aware of your many well-rehearsed rebuttals to my points. A common impulse physicians experience in response to the threat you represent is to withdraw, practice rigidly defensive medicine, change specialties or leave medicine entirely. I reject these, because to give in to fear would be to give up being the kind of person and physician I want to be.

Ben, you and I have known each other for years. I had come to like, trust and respect you. It is therefore with an extra measure of sadness that I acknowledge I cannot overcome the barrier your career has placed between us. I cannot recover the trust in you I once had.

Your work helps push our medical professional liability system out of control. This destroys the basic relationship essential to good health care. Physicians and patients need a delicate mutual confidence not easily restored once it is damaged by suspicion or open attack. So do friends.

So, unlike you and your colleagues, I do indeed take it personally. We cannot go back to the friendship you and I once had, and for that I grieve.

Sincerely,

George

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

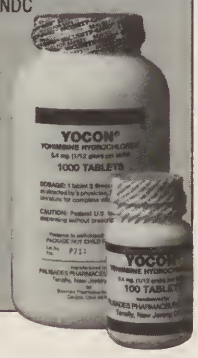
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Data bank

(Continued from page 9)

PPOs feel they need to credential the physicians participating in a network," said Mike Vitek, director of the AMA's hospital medical staff services department. "But the law doesn't allow them to query the data bank directly."

Physicians are hesitant to comply with self-query requests because it is unclear whether the data bank's confidentiality guarantee covers reports that physicians provide to unauthorized entities, Vitek said. That is a critical issue for physicians, because the information contained in data bank reports is highly sensitive, according to the AMA. "Most of us feel pretty comfortable within our hospital staff framework that the confidentiality will continue to exist," said Dr. Kobler. "But we don't write the bylaws for the PPO [requesting a physician's report], and I'm not sure we can always count on the provisions of confidentiality being there."

According to Vitek, data bank officials have said that federal regulations and statutes do not include provisions allowing them to stop unauthorized entities from asking physicians to self-query. The AMA is working with several federal agencies to implement safeguards that would ensure the confidentiality of physicians' self-query reports. Meanwhile, the AMA and ISMS suggest that when any unauthorized entities ask physicians for data bank reports, doctors should send a letter outlining the conditions under which they will fulfill the request. (See the AMA sample letter, page 9.)

"The letter reinforces the need for confidentiality and puts the entity on notice that the report is being provided for one purpose only, and that is to credential the physician to work in that one particular network," Vitek said. "They're not to send the report to some other entity."

The AMA and ISMS have called for the dismantling of the data bank, but Vitek said that prospect is unlikely. President Clinton's health system reform proposal includes references to the data bank and possible requirements for the U.S. Department of Health and Human Services to create regulations giving the public access to the data bank.

Dr. Kobler called that possibility frightening. He said he is particularly concerned about the release of malpractice settlement information included in data bank reports. "Statistics have shown that more than 75 percent of what has been reported to the data bank concerns malpractice. We know that a malpractice judgment against a physician doesn't mean he or she is not a good doctor, but the data can be misused or misinterpreted by people who don't understand it." ■



Amy Rothblatt

PETER A. BRUSCA, MD, a Carol Stream otolaryngologist, talks to ISMS and ISMIE employees Oct. 7 about the mounting daily challenges physicians face in the changing health care climate. Dr. Brusca's presentation was one of 12 such programs conducted by members of the Exchange Board of Governors during recent all-employee training sessions.

New lobbying law affects 1994 dues

Medical society dues for 1994 paid in calendar year 1993 will be affected by the new federal law disallowing tax deductions for lobbying expenses, according to the Internal Revenue Service. The IRS recently issued guidelines stating that even if 1994 dues are paid prior to Dec. 31, 1993, the new tax laws apply to these payments. The IRS has not indicated when rules will be issued, but ISMS will keep members informed. In December, ISMS members should watch for the official notice regarding the portion of dues payments attributable to lobbying expenses and not deductible as an ordinary and necessary business expense. ISMS recommends that members consult their personal tax advisers regarding individual tax circumstances. ■



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NEW DRUG THERAPIES

Unlocking the secrets of Alzheimer's disease

Studies show promise for treating the frustrating disease that afflicts more than 4 million people.

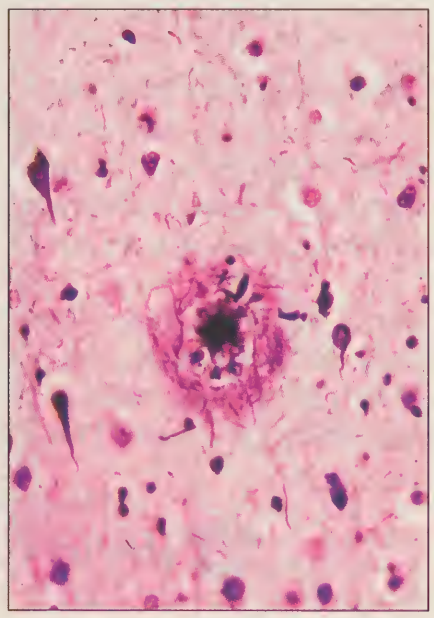
BY RICK ASA

Alzheimer's disease places tremendous emotional and physical burdens on those who suffer from it and their families. In addition, its socioeconomic impact on society is enormous: It is one of the most expensive diseases to treat, with cost estimates running $70 billion to $90 billion per year in the United States. In 1991, Alzheimer's treatment in the United States cost $72 billion and exceeded $44,000 per patient, according to Joel Hay, a University of Southern California health care economist.

There may be some relief in sight, however, as researchers are reporting breakthroughs. This month, Duke University announced study results regarding the gene apolipoprotein-E and its role in Alzheimer's risk. The discovery may lead to development of a diagnostic test.

Research is also producing new drug therapies, including a medication that can slow cognitive degeneration in some Alzheimer's patients. During an Oct. 23 conference sponsored by the University of Illinois at Chicago neurology department, medical researchers expressed optimism about this drug, tactrine, known by the brand name Cognex.

Clinical trials have shown the drug to be effective in some patients who experience a mild-to-moderate form of Alzheimer's. Although tactrine is not a cure, it is the first drug treatment for the estimated 4 million Americans with Alzheimer's disease. The drug recently received U.S. Food and Drug Administration approval.



Senile plaque, shown above, has been linked with the severity of patients' dementia.

BECAUSE LIFE EXPECTANCY and longevity are increasing, Alzheimer's disease is potentially the most expensive illness to treat, said Daniel B. Hier, MD, head of the UIC neurology department. About 90 percent of nursing home patients have a cognitive impairment or Alzheimer's disease, Dr. Hier noted, adding that long-term care is rapidly becoming the most expensive part of the health care system. "The economic impact of extending life without improving cognitive function means the number of nursing home residents would increase, and the economic load – since this is basically a nonproductive segment of society consuming resources – is potentially an extremely large burden on society."

Effects on patients' families and society also add to the spiraling costs associated with Alzheimer's, said Martin R. Farlow, MD, director of neurology outpatient clinics at Indiana University and the principal investigator of one of the two controlled, double-blind clinical studies of tactrine. According to Dr. Farlow, even a drug like tactrine, which treats patients' symptoms in only certain cases, would be welcomed by burdened care givers. "What might it be worth to a [family member] care giver

who might otherwise be working?" he asked.

New treatments could also mean reaching more patients with Alzheimer's, because physicians would have a stronger impetus to recognize the disease, Dr. Farlow said. "There was not as great an interest in recognizing symptoms, because there was no motivation. Now, more people will be reached, because physicians have something to offer in terms of treatment. [Tactrine] provides motivation as the first drug."

PHYSICIANS STUDYING Alzheimer's and other cognitive disorders are entering what Dr. Hier calls the "decade of the brain," during which these doctors will attempt to create a manual for repairing the human brain and give other physicians the tools to do the work. "The next five to 10 years are going to be about building that repair manual and getting some of the tools we need. Cognex is important because it meshes with growing knowledge as to what is wrong in Alzheimer's disease and specifically corrects a biochemical abnormality. This is the beginning of many therapies for Alzheimer's that will be physiologically based."

In some Alzheimer's patients, tactrine improves their intellectual function and their ability to perform many routine daily activities, said Dr. Farlow. He said he has also found evidence of cognitive improvement in patients taking the drug.

According to Dr. Farlow's research, increased dosages would probably lead to even better results. Another clinical trial that tested the drug at much higher doses resulted in heightened improvement, including enhanced quality of life, as measured by a global assessment, Dr. Farlow said.

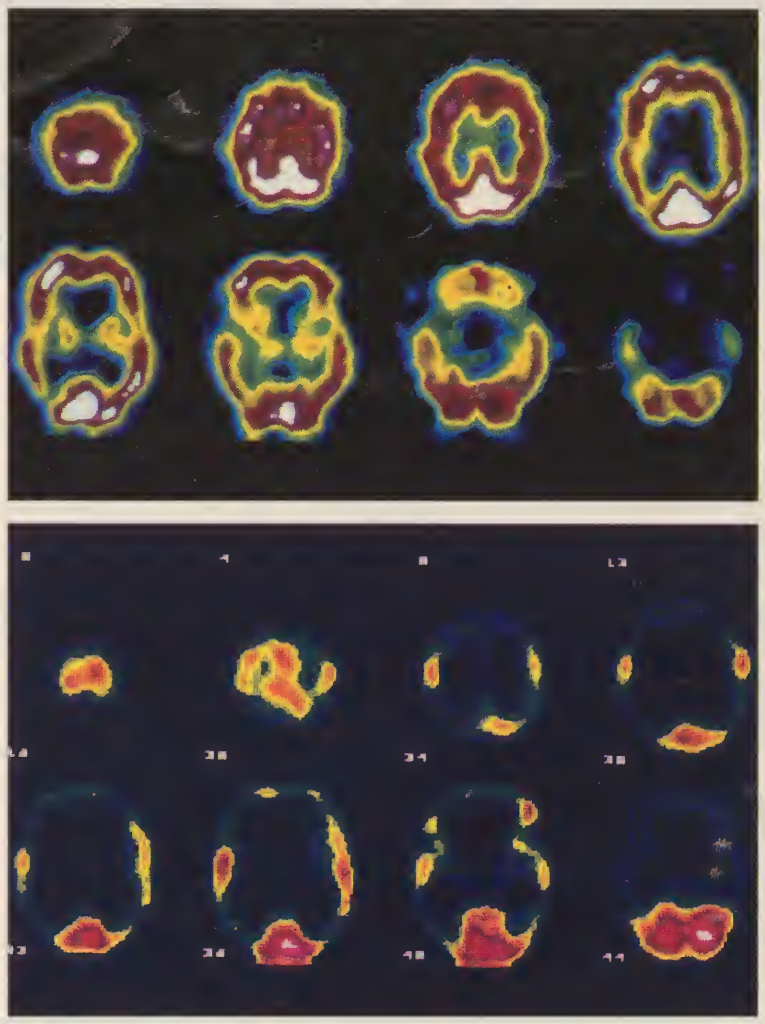
Tactrine is an acetylcholinesterase inhibitor, which may bolster cognitive function by preventing the destruction of acetylcholine, according to some scientists. Destruction of neurons that produce acetylcholine – a neurotransmitter that allows communication between neurons in different parts of brain – is typical of Alzheimer's disease, Dr. Farlow explained. That change occurs in the temporal lobe regions of the brain, which are responsible for memory.

Potential liver damage is one major side effect of the drug, Dr. Farlow said, adding that during the study, this was controlled with weekly monitoring. Other side effects – diarrhea, vomiting, abdominal pain, dizziness, headache and rash – are also controllable, since they are anticipated symptoms associated with a drug that raises patients' acetylcholine levels.

The next five to 10 years are going to be about building that repair manual and getting some of the tools we need.

Dr. Farlow said he believes physicians may order complex neurophysiological tests before prescribing tactrine, but he stressed that global measures, such as interviews with patients and their families, have proved at least as important in assessing the drug's effectiveness and use.

"We know there are a number of doctors who don't seem interested in prescribing Cognex because they feel it's minimally effective," said Joann McConnell, PhD, a neuroscience researcher and senior vice president of medical and scientific affairs for the Chicago-based Alzheimer's Association. "The long-term drawback of the drug is that it won't stop the process of the disease, and so theoretically [it] won't be very effective for a long period of time, but quality of life is critical.



SPECT scanning allows physicians to see the topographical distribution of brain dysfunction, as well as any decrease in blood flow and metabolism. A scan of a normal brain (top) shows marked differences from a scan of a brain in late-stage Alzheimer's (bottom).

"We're hoping that current research will point the way to a more effective drug, and certainly what we've seen happening in the last year is encouraging," Dr. McConnell added. "We feel very strongly that within 10 years, there will be an understanding of what Alzheimer's disease is, and that will include an awareness that there is not just one type."

Dr. McConnell predicted that within the next four years, researchers will begin testing new treatments that would actually stop Alzheimer's progression. Dr. Farlow said he believes other drugs that would raise acetylcholine levels in the brain could be on the market within three years. "Obviously, we're just taking our first steps," he said.

Dr. Hier stressed the need for physicians to become more adept at distinguishing Alzheimer's from similar diseases that cause dementia and at identifying subtypes of Alzheimer's with rapid or slow courses. "We'd like to see those people who meet the diagnostic criteria for Alzheimer's disease be identified as Alzheimer's patients and be treated as such. We want to see it given a name instead of calling it organic brain syndrome or senility."

The development of scanning technology over the last 20 years has greatly improved neurologists' ability to diagnose Alzheimer's, Dr. Hier said. Single photon emission chromatography (SPECT) scanning, for example, reveals the topographical distribution of brain dysfunction. It also shows decreases in blood flow and metabolism even when CT and MRI scans

(Continued on page 14)

Alzheimer's

(Continued from page 13)

appear normal, according to Dr. Hier. Researchers, including a team at UIC, are also enhancing MRI to help them evaluate brain metabolism in addition to structure.

Decreased acetylcholine levels have also been connected with the formation of senile plaque deposits, which in large amounts have been linked to the severity of dementia, Dr. Hier said. Some research has found that raising acetylcholine levels in tissue cultures reduced production of the plaques, Dr. Farlow added.

According to Dr. Farlow, other possible causes of Alzheimer's that are being studied include nerve growth factor deficit; intracellular calcium toxicity; inflammation (Alzheimer's prevalence seems to be lower in patients taking arthritis drugs); and the hypothesis that free radicals produced by oxidation may be toxic to nerve cells.

AS MORE IS UNDERSTOOD about the causes and treatment of Alzheimer's, community-based doctors will probably begin to want experience in treating the disease, Dr. Hier said. "If they don't, they can still refer the patient to an academic medical center."

Since community-based physicians will continue to be patients' primary care givers, they should learn more about the types of behavior caused by Alzheimer's, such as disruptive agitation and depression, said Murray Raskind, MD, vice chairman for psychiatry and behavioral sciences research development at the University of Washington.

Differentiating true symptoms of depression from symptoms of Alzheimer's is complicated, said Dr. Raskind. For example, two of the hallmark symptoms of major depressive episodes – diminished interest and weight loss – could be attributed to Alzheimer's. No evidence exists to suggest depression in older patients is a precursor to dementia, Dr. Raskind added. However, "no one knows how commonly secondary major depression complicates Alzheimer's."

In addition, no studies have shown that treating Alzheimer's patients with anti-depressants works any better than a placebo, Dr. Raskind said. Anti-psychotic drugs are also widely prescribed, he noted, adding that up to 39 percent of nursing home residents are taking these drugs. Only three placebo-controlled studies have been conducted on Alzheimer's patients who were taking anti-psychotic drugs. Results indicated better efficacy than with anti-depressants but more adverse side effects.

"The way to work with these people is to use a behavioral biomedical approach, trying to maximize pleasurable activities and increasing activity levels and showing more attention, which can have a therapeutic effect on their mood function," Dr. Raskind said. "Behavioral and environmental treatment strategies for depression in Alzheimer's patients deserve careful consideration." ■

IDPR DISCIPLINES

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January 1993

John Ferris, Arvada, CO – physician and surgeon license indefinitely suspended after being disciplined by the State of Arizona.

Vuho Zecevic, Chicago – physician and surgeon license placed on probation for six months after writing prescriptions for a controlled substance on a non-triplicate prescription form.

February 1993

Joseph Alfred Meis, Harvey – physician and surgeon license reprimanded and fined $2,000 for gross negligence.

Sylvester Nathan, Chicago – physician and surgeon license placed on probation for five years and fined $5,000 after alleged dishonorable, unethical and unprofessional conduct.

Natwarlal G. Ruparell – physician and surgeon license placed on indefinite probation for a minimum of five years for failure to comply with an agreement of care counseling.

Joseph Sowers, Fulton – physician and surgeon license indefinitely suspended after being disciplined in the State of Kentucky.

Mustafa Vidinli, Aurora – physician and surgeon license placed on probation for two years for gross negligence.

Cornelius Whalen, Charleston – physician and surgeon license placed on probation for two years and fined $5,000; controlled substance license indefinitely suspended after alleged improper prescribing of narcotic analgesics.

March 1993

George S. Beard, Hopkinsville, KY – physician and surgeon license indefinitely suspended for a minimum of six months after being disciplined in the State of Kentucky.

Augustine Dormitorio, Naperville – physician and surgeon license placed on probation for one year; controlled substance license placed on indefinite probation after prescribing a controlled substance under questionable circumstances to some patients and a Department investigator. ■

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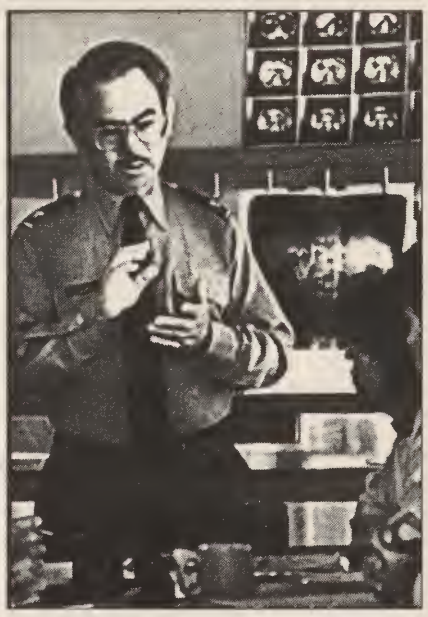
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Economic credentialing

(Continued from page 1)

economic credentialing problems exist. These included two attorneys offering a hospital-governance perspective and a physician administrator who said he supports the concept of economic credentialing, if "sound techniques" are used to determine whether a physician's work is "inappropriate."

"Economic credentialing does exist and has the potential to jeopardize quality of care," Dr. Traugott said. He told the board members that the AMA defines economic credentialing as the "use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continued hospital medical staff membership or privileges."

Through economic credentialing, hospitals may make clinical privilege decisions based on the types of patients physicians treat, physicians' profitability to the hospital or other purely economic criteria not directly related to quality of care, Dr. Traugott said. "Economic credentialing means physicians' privileges can be revoked for factors such as patient resource utilization compared to profits, participating or contracting status with government and commercial payers, payer mix, liability risk and insurance cost, and referral patterns. While hospitals may take these factors into consideration, it is in society's interest to ensure that quality is considered in an appropriate manner. We should be seeking the best physicians, not the physicians who can generate the most money."

"Over the years, I have noticed economic credentialing in a number of arenas," said Glen Ellyn thoracic surgeon Raymond A. Dieter Jr., MD. He said physicians and their patients will be hurt if doctors are terminated from hospital medical staffs for failing to admit enough patients or conducting an insufficient number of surgeries or other procedures. For example, patients may have to travel farther to see the physician if they decide to keep that same doctor. And physicians may be forced to apply elsewhere for admitting privileges. They may have to move their offices and may no longer be able to afford liability insurance. "It's very difficult to start a new practice when you have your home purchased and your children leaving for college," he said.

"It's not only doctors who are hurt by economic credentialing," said Arvind K. Goyal, MD, a Rolling Meadows family physician. "By its very nature, economic credentialing creates a subtle pressure to place the hospital's bottom line above the needs of patients. The cruel irony is that economic credentialing most profoundly impacts the patients least able to understand it and defend themselves – the very sick, the poor and those with no or inadequate medical insurance – those whose hospitalization does not generate money for the institution.

"Economic credentialing removes an important element of choice from the patient," Dr. Goyal continued. Physicians may receive only a few days' notice when their privileges are terminated, forcing patients scheduled to receive inpatient treatment to make alternative arrangements to see their physician or begin seeing a new or unfamiliar doctor, he noted.

THE ILLINOIS RADIOLOGICAL Society "strongly endorse[s] efforts to prevent economic credentialing," said IRS President Jerry P. Petasnick, MD. "Granting and terminating medical privileges should not be based on economic considerations. It's a distinct possibility that the type of patient in a physician's practice could take the place of a valid basis for granting privileges. We feel that both patient welfare and physicians' rights are compromised [through economic credentialing].

"Any physician who has gone through the credentialing process and obtained medical staff privileges is entitled to full procedural due process before these privileges are curtailed, as provided by the fair hearing plan in medical staff bylaws," Dr. Petasnick continued. "Hospital governing boards should bridge a physician's privileges only upon recommendation of the medical staff for reasons related to professional competence, adherence to appropriate standards of medical care, health status or other parameters agreed upon by the medical staff."

Added Dr. Traugott: "It is important to remember that in spite of all other organizational and institutional concerns, the overriding factors that must guide all [credentialing] policy initiatives are the quality of patient care and access to that care. It is critical that we begin by identifying how economic credentialing occurs and then discussing remedies." ■

Medical educators

(Continued from page 1)

to put the screws on."

Dr. Mennen said he believes students will enter primary care fields based on their perceptions about practicing in those areas of medicine. "Students tell me that if the remuneration and lifestyle were better, they would go into primary care. Society dictates what fields physicians choose."

In addition, Dr. Mennen said he is concerned about lawmakers' emphasis on lowering health care costs. "Everyone would agree that changes are beneficial if done properly. But medicine should not be based on the dollar. In everything we hear and read, patient care has been glossed over. Patients should be able to get the necessary care without being penalized."

Federal and state governments are also likely to influence students' specialty choices by providing scholarships and debt forgiveness programs for those who select primary care, according to Charles C.C. O'Morchoe, MD, director of the University of Illinois College of Medicine at Urbana-Champaign.

Dr. O'Morchoe said he predicts government will also promote family practice by continuing to increase Medicare reimbursement for residency programs in this area and diminishing funding for specialties and subspecialties.

FAMILY PRACTICE RESIDENCY PROGRAMS have recently had trouble filling their available slots, said Thomas Dent, MD, director of the Illinois Masonic Medical Center's family practice residency program, which is affiliated with Rush Medical College. "Student interest in primary care specialties has decreased."

"I take offense at the notion that medical schools are subverting students into specialties," Dr. Booden said. "My feeling is that students choose four or five fields before coming to medical school. Sixty percent to 70 percent end up in one of those fields. We have to find out what is turning them away from generalist specialties before medical school."

Educators are also seeing increased demand for physicians to be retrained in family practice, said Jerry Kruse, MD, program director of the Quincy Family Practice Residency Program, affiliated with the Southern Illinois University School of Medicine. "We need to develop ways to provide additional training," he said, adding that family practice residency programs will probably become more involved in training physician assistants and nurse practitioners.

One concern for residency programs is that their patient volumes may decrease under a reformed health system that increases managed competition and offers universal access to health care, Dr. Kruse said. This is because special patient populations will probably be targeted in the marketing campaigns conducted by larger health alliances, he explained.

"All medical schools will pay a lot more attention to the component of education dealing with reform policy and the cost of health care," Dr. O'Morchoe said. Urbana-Champaign's dual-degree program, which encompasses more than 40 disciplines including biochemistry, physics, engineering and the medical humanities, trains students for careers in academic medicine. Dr. O'Morchoe said he believes research will continue to be conducted at academic medical centers, but the focus may change.

> ***Everyone would agree that changes are beneficial if done properly. But medicine should not be based on the dollar.***

"Health policy research will expand in the areas of treatment outcomes and practice parameters," Dr. O'Morchoe continued, adding that the traditional emphasis on research in the subspecialties may decrease. "I have some concern that this may limit the ability to develop new treatments. We treat rather than cure most diseases. We use the treatment that is optimal, and this changes from time to time."

"We really do have to examine the equation as to what medical schools are responsible for," Dr. Booden said. "I don't think anyone can say they're not concerned. I'm optimistic because medicine has traditionally been able to adjust. It is a noble field. Young people are still caring and feeling." ■

ER visits

(Continued from page 1)

that is caused by cocaine use," Dr. McDermott said. "And we always ask if they are [using] cocaine. That has become a standard question, especially of younger people having chest pains. It is a reflection of the problem that we have to ask [those questions]. It has become part of our standard triage protocol."

Although there may be growing awareness about the effects of drug abuse, it has had little or no impact on the use of controlled substances, said Dr. McDermott. In fact, admissions to the DASA treatment program show a trend of earlier and heavier drug use, Long said. The peak age of first marijuana use among addicted children is 13; for alcohol and cocaine, it is 15; and for opiates such as heroin, first use is typically at 16, according to DASA.

"The problem with drug-related visits is that these patients stay longer, and they require more staff. They are complicated cases with unreliable [medical] histories," said Jerrold B. Leikin, MD, director of the poison control center in the emergency department at Rush-Presbyterian-St. Luke's Medical Center. "Patients are often agitated, uncooperative, unpredictable and sometimes delusional or paranoid. Observance is key. You have to watch them over a period of time, and they require more intensive monitoring. Sometimes we need to place security guards with them."

THE PREVALENCE of drug-abuse patients causes other problems for emergency departments, including the dilemma about what to do with patients after their initial treatment, said Dr. Leikin. "We can't just discharge these people back out onto the street. They have to leave with someone else, be admitted to the hospital or go to a detoxification program. The current irony is that you need money to get into detox, and the people who need detox most can't afford it. It becomes a social problem as well as a medical problem."

The problem is more severe at Cook County Hospital, according to Dr. McDermott. "A large percentage of our ER patients are [uninsured], and we don't have very many treatment options. We can't afford an in-house treatment program, and our patients can't afford outside treatment centers. People come to us looking for a way to quit. They tell us they want to quit, but there is nothing we can do. We have very few options to offer them."

Dr. Leikin said he is concerned DAWN's study results may underestimate the problem, because they focus on "traditional" street drugs. There are no generally accepted tests for measuring "nontraditional" drugs, such as nitrous oxide and some substances that are sniffed, such as glue, paint and gasoline, he said. "There may be a plethora of nontraditional street drugs out there that are not detectable by current analytical toxicological techniques. So the prevalence of this problem and its demographics aren't counted, and the approach to the drug problem is restricted to drugs we have accepted as traditional."

In addition, the problem of substance abuse goes beyond what society considers illegal drugs, Dr. McDermott stressed. "As long as we keep talking about drugs as being heroin and cocaine, and not alcohol and tobacco, I see no hope for improvement. We can't keep saying one is acceptable and the other is not. As far as I'm concerned, it is no worse to have a small amount of cocaine in your home than it is to have a pint of whiskey. In the ER, we see the medical complications of alcohol and cigarettes much more than those of other drugs." ■



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UT CAPS, FORGET REFORM (PAGE 9)

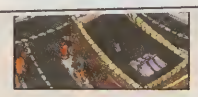
FEDERAL LAWMAKERS DISCUSS SYSTEM REFORM OPTIONS

PAGE 5

Illinois Medicine

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PAGE 12

Hospitals form networks

TRENDS: Health care facilities prepare for reform. By Anna Brown

[CHICAGO] To secure greater muscle in the health care market, Chicago-area hospitals have recently vied for positions in rapidly growing networks. And even as hospitals announce new affiliations, the next moves are being discussed behind closed doors, according to network executives. Such activity has been hastened by President Clinton's support of a managed competition health care model and by a general shift in health care trends within the private sector, industry observers said.

"Strategically, the more integrated the health care, the more likely the continuum of care will be enhanced," said Steven Scheer, Illinois Hospital Association executive vice president. Ultimately, affiliations will improve access and availability of care, he noted. Large integrated networks will be better positioned to respond to predicted changes in the health care system, he added.

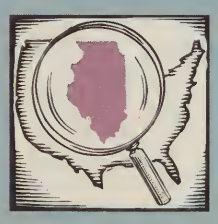
Physicians are also being affected by these changes, said William E. Kobler, MD, chairman of the ISMS Hospital Medical Staff Section Governing Council. "A lot of physicians will have to make some hard decisions, because the future is so uncertain. Partner-

(Continued on page 19)

INSIDE

Department on aging readies for the future

PAGE 3



Officials condemn gun violence

PAGE 14

DEPARTMENTS

News Briefs 2
Commentary 6
Letters 7
ISMIE Update.....9
Classifieds.....16
IDPR Disciplines ..18

Insurance companies consider reform concepts

REACTION: The insurance industry examines its role in health system reform. By Gina Kimmey

[CHICAGO] The Clinton health system reform proposal should more directly address the problems of the U.S. health care system, according to former Vice President Dan Quayle. Speaking to the Professional Liability Underwriters Society in Chicago on Nov. 11, Quayle said a government-run health care system is not the answer to problems in the current system. Instead, they could be corrected by implementing tax credits and vouchers, he said.



Wm. Daniels/The Photo Partners

Former Vice President Dan Quayle tells a group of insurance underwriters that the U.S. health care system would become more inefficient under government control.

"When was the last time the federal government took over anything and made it cheaper?" Quayle asked. "It is not going to make the system more efficient. It is going to make it more inefficient. And, therefore, it will be more costly rather than less costly. We ought to have universal opportunity for health care coverage, but not have the government mandate it."

Many health insurance executives share the former vice president's feelings on that issue. Although President Clinton's call for universal access, a standard benefits package and insurance reforms is desirable, the means to achieve those ends are not, said Lawrence English,

(Continued on page 19)

Chicago passes lead poisoning ordinance

PUBLIC HEALTH: Stricter regulation of lead levels in residential buildings may improve abatement efforts. By Anna Brown

[CHICAGO] The Chicago City Council approved an ordinance Nov. 5 to help prevent childhood lead poisoning. The ordinance passed one day after the council's Committee on Buildings and Health heard testimony in support of the measure from public health officials and parents of lead-poisoned children. The council's action makes the presence of lead in buildings illegal, even if no children living in the buildings have been diagnosed with elevated blood lead levels.

"By making clear that the laws are violated wherever lead-based paint exists, the new ordinance would provide an incentive to correct lead hazards before a child becomes poisoned," said Chicago Health Commissioner Sister Sheila Lyne during the Nov. 4 hearing. The new ordinance "shifts the burden [of lead detection and abatement] to building owners, informing them that they have the responsibility to determine whether there is a lead paint problem for their tenants and to take corrective measures. It empowers the city to inspect all buildings, whether or not a

(Continued on page 18)

ISMS BEHIND THE SCENES

SOCIETY OPPOSES MANDATED PRACTICE GUIDELINES

ISMS is expressing serious concerns about the recent announcement by Blue Cross and Blue Shield of Illinois that physicians who choose to participate in the company's new specialist referral network must follow clinical practice guidelines, said Jere E. Freidheim, MD, chairman of the ISMS Board of Trustees. About 1,300 Illinois cardiologists, oncologists, and general and orthopedic surgeons may soon be faced with mandated adherence to practice guidelines the insurer has established for 14 medical procedures.

"We are troubled that an insurer is attempting to dictate how physicians treat their patients," Dr. Freidheim said. "We do not know the substance of the guidelines. As physicians, we must stand together and resist the intrusion into medical practice by insurers who are interested in their financial bottom line rather than quality medical care for patients.

"Patients' needs must come first in any med-

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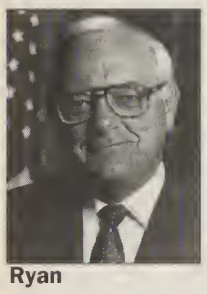
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Lower DUI limits sought

SURVEY: Illinoisans favor lowering legal alcohol limits.
By Anna Brown

[CHICAGO] Secretary of State George H. Ryan announced Nov. 3 that he will reintroduce legislation in the spring to reduce the minimum acceptable blood alcohol content for motorists. Currently, individuals are considered to be driving under the influence when their blood alcohol level reaches .1 percent. Ryan said his bill will call for the legal limit to be .08 percent. Ten states have already enacted such legislation.

Ryan's announcement at a Chicago press conference followed the release of survey results showing that Illinois voters supported lowering drivers' acceptable blood alcohol content.



Ryan

"Legislators who have been wondering how the public feels about this issue don't have to wonder anymore," Ryan said. Conducted by Kemper National Insurance Cos., a telephone survey of 800 Illinois registered voters found that 61 percent favored decreasing blood alcohol limits.

"The .08 proposal is a very important component of the overall effort to remove drunken drivers from the road," said Sen. David Barkhausen (R-Lake Forest), who sponsored a similar measure that was held in committee this year. "No one with a .08 blood alcohol content should be getting behind the wheel of a car."

Ryan added that vehicle crashes are the leading killer of people under 45 in the United States. "They are the biggest cause of permanent disabilities in our nation. And nearly half of those crashes every year can be laid at the door of a drunken driver."

"Physicians are among the first to see the horrible toll motor vehicle accidents take on human life," said John J. Ambre, MD, director of the AMA's department of toxicology and drug abuse. "Driving is a task that involves a complex array of physical and mental activities, such as judgments of traffic movement, estimation of distances and reaction to unexpected hazards. Alcohol has effects on the nervous system like those of a general anesthetic. It interferes with those critical driving skills, impairs coordination, prolongs reaction times, distorts judgment, reduces vigilance or attention to traffic conditions, and increases risk taking."

To reach the .08-percent level, a 160-pound person would need to consume about four drinks in an hour on an empty stomach, Dr. Ambre said.

According to Ryan, the legislation would deter individuals from driving while impaired, because it would establish a legal alcohol limit at which driving skills are proved to be compromised for most drivers. At .08 percent, a person is three times more likely to be involved in a car crash than is a sober driver and 11 times more likely to be involved in a fatal single-vehicle crash, Ryan said. ■



Wm. Daniels/The Photo Partners

FIFTH-GRADE STUDENTS at the Ericson South Academy in Chicago hold hands, forming a circle around the school to protest drug abuse during Drug Awareness Week in October.

Reach Out expands care for underserved patients

[PRINCETON, NJ] Helping physicians expand access for the underserved is the goal of the Robert Wood Johnson Foundation's Reach Out program. The $14-million program is designed to help physicians develop new approaches to care for people in their communities who have difficulty obtaining medical care.

"There are many practicing physicians who are very troubled by the holes in our delivery system that leave millions of people with inadequate [care] or a complete lack of care," said H. Denman Scott, MD, director of Reach Out and senior vice president for health and public policy for the American College of Physicians in Philadelphia. "This program will develop models linking thousands of Americans to a coordinated system of services and to an ongoing physician relationship that will enhance continuity of care and the prevention and early identification of disease."

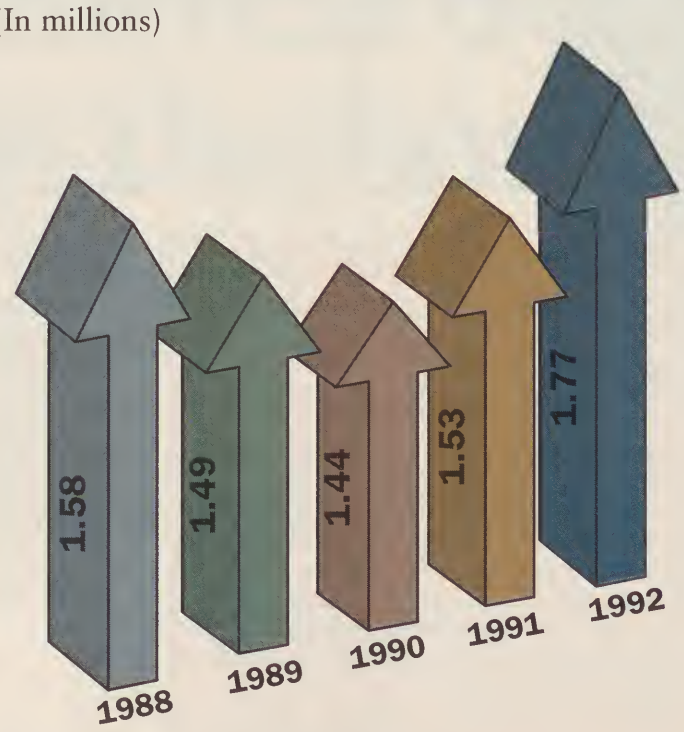
Under the program, organizations in 40 to 50 communities representing practicing private physicians will develop and implement local or regional projects to expand the role of private physicians in providing care to people who are medically underserved. The program does not require that any specific model be used, but projects should establish partnerships between primary care providers, hospitals, health departments and state agencies to increase the number of underserved people receiving primary care from their community's private physicians. The program is targeting individuals who lack insurance, are on Medicaid or have disabilities or chronic mental illnesses, as well as AIDS and HIV-infected patients, high-risk adolescents and the homeless.

For more information, contact the Robert Wood Johnson Foundation at (609) 243-5937. ■

PHYSICIAN FACTS

HMO enrollment growing in Illinois

(In millions)



Source: Group Health Association of America

Health center receives grant from Northwestern

[CHICAGO] The largest federally funded community health center in Illinois, the Erie Family Health Center, has received a $20,000 grant from Northwestern Memorial Foundation. Located on Chicago's West Side, the center provides access to affordable care to West Town, Humboldt Park and Logan Square residents, regardless of their ability to pay.

The center offers prenatal care, delivery and family planning services, as well as routine well-child and adult care. Center staff also provide hospital care and follow-up, health promotion and education, mental health and nutritional counseling, social services and referrals, and crisis intervention. Government-sponsored programs for women, infants and children are also administered through the health center.

The clinic was founded in 1956 with the help of Northwestern Memorial Hospital and its medical staff. ■

Elmhurst physicians perform rotablator procedure

[CHICAGO] Two cardiologists at Elmhurst Memorial Hospital were the first Chicago-area physicians to perform a new coronary rotablator procedure. Louis S. McKeever, MD, and John M. Cahill, MD, are among the fewer than 100 physicians nationwide who have been certified to use the rotablator device. It was approved by the U.S. Food and Drug Administration in June.

The coronary rotablator system is designed to remove plaque lesions that block arteries, restricting the flow of blood to the heart, according to an Elmhurst Memorial Hospital spokesperson. By destroying the obstruction, the artery opening is increased and blood flow is improved, the spokesperson said.

"An advantage of the rotablator procedure is that it is less costly and less invasive when compared to bypass surgery or angioplasty, and it allows us to treat a greater number of patients," said Dr. McKeever.

The rotablator device is equipped with a tiny football-shaped tip coated with microscopic diamond crystals. It is designed to remove only the plaque and does not harm the surrounding arterial tissue, said a hospital spokesperson. As the tip travels through the blocked area, it breaks the plaque build-up into particles smaller than red blood cells. The microscopic plaque particles then travel through the patient's bloodstream and are removed by the body's waste system. According to Dr. McKeever, the procedure has a 90-percent success rate. ■

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Department on aging readies for the future

ELDERLY: Project 20-20 considers the growing needs of seniors. By Gina Kimmey

[SPRINGFIELD] At a hearing held Oct. 20 by the Illinois Department on Aging, testimony centered on the issue of long-term care for seniors in Illinois.

The hearing focused on meeting the needs of the older population, maximizing cost-effective services, evaluating Illinois' regional network of service delivery and looking at the aging network as a model. Individuals who testified generally supported increasing in-home and community-based care to postpone or avoid placing older adults in nursing homes.

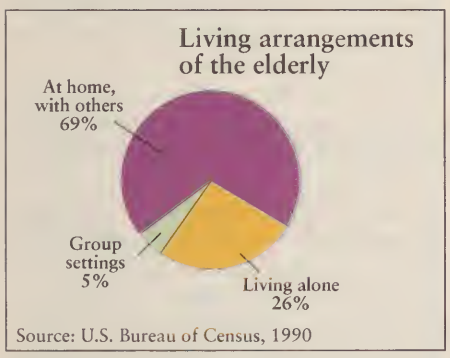
The Illinois General Assembly mandated the hearing as part of IDOA's Project 20-20 – a series of community forums about how to improve services for seniors in Illinois and prepare for their future needs.

"The elderly population will greatly expand, so as we look back 20 years on our progress, we need to look forward 20 years," said Cheryl Sugent, manager of the department's Division of Older American Services. "This will affect everyone serving seniors."

Marion Bond, testifying on behalf of the Atlas Senior Center in Chicago, compared the $28,500 annual cost to care for a nursing home resident with the monthly cost of $1,000 per participant in a community-based care program. "The agencies dealing with seniors must be proactive," she added. "We have to address elder abuse and improve access to community-based care programs."

Seniors spend enough on medicines so that pharmaceutical companies should help support senior programs, another person testified. "Some of that money should be returned to the seniors. Why can't pharmaceutical profits be taxed and the money used to help pay for in-home care?"

Others were concerned with the issues facing senior health care when health system reform becomes reality. "The health care reform proposals are calling for Medicare cuts, and cuts in research funding for Alzheimer's and heart disease," testified a representative of Chicago's Southwest Senior Center. "Doctors already say Medicare rates don't cover their costs. Seniors are afraid doctors won't help them anymore."



According to IDOA statistics, almost one in five Illinoisans is age 60 or older, totaling 1.9 million elderly. One in four seniors lives alone; these individuals are among the most vulnerable and impoverished people in Illinois. If assistance is needed, these senior citizens must rely on formal support through community services and the "aging network."

Traditionally, the aging network has referred to the system of funds the Federal Administration on Aging disburses to IDOA, which, in turn, distributes funding to 13 area agencies on aging. The agencies can then contract with local senior services providers. But that definition has broadened over the last 20 years, according to Nancy S. Nelson, IDOA deputy director.

"Now we consider the aging network to include more partners, such as [the American Association of Retired Persons], community organizations and anyone who provides care and services to the elderly population," said Jan Costello, IDOA spokesperson. "Physicians are part of that broadened definition. We need to create partnerships with doctors and hospitals, to coordinate services that are available and make sure those services are not fragmented or duplicated."

After completion of the forums, IDOA will submit a final report of recommendations to the General Assembly. "Illinois should be proud of the advances we have made in serving seniors for the past 20 years, but the increasing demand for services means the state must be even more cost-effective in administering health and human services to older Illinoisans," said Maralee I. Lindley, IDOA director.

"Sometimes we feel we are working at a snail's pace, but when we look back, we see some real progress," said Nelson. "We have expended a lot of sweat and tears in the last 20 years, but there are new rules we need to look at for the next century."

The remaining two forums are scheduled for Dec. 8 in Belleville and Dec. 16 in Carterville. For more information, contact IDOA at (800) 252-8966. ■

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REPORT FOR *Illinois Physicians*

USE OF THE -22 MODIFIER ON CLAIMS SUBMITTED TO MEDICARE

Claims that are being submitted to Medicare Part B with the Current Procedural Terminology (CPT) "-22 modifier" placed on procedure codes indicate that physicians and their billing staffs do not have a clear understanding of the use of this modifier.

The -22 modifier pertains to additional payment requests for unusual procedural services; that is, "When the service(s) provided is greater than that usually required for the listed procedure." This modifier can be applied only to the primary procedure performed. It can be used in the same way by an assistant-at-surgery.

When a physician decides to request additional payment for a procedure by placing the -22 modifier on the procedure code, the physician must describe an increment of work that is normally not encountered with the procedure and is not identifiable by another CPT code. This documentation, which can be in the operative report, a letter, or both, should accompany the claim.

The -22 modifier does not pertain to a physician's specialty or to complicated post-operative management, including critical care. It could be applicable to high-risk trauma surgery or a significantly-extended procedure.

The submission of a claim with a -22 modifier does not assure additional payment for the procedure.

(Issue: 12/03/93 - DB)

Making teen health a priority

PREVENTION: Through school-based health centers, the Ounce of Prevention Fund aims to improve the quality of life for disadvantaged teens. By Gina Kimmey

[CHICAGO] A portion of $3.7 million in social service grants awarded by Gov. Jim Edgar in September will help provide access to primary care for more than 3,000 Chicago high school students. The grants, totaling $472,485, were awarded to health centers at DuSable High School, Rezin Orr Community Academy and Crane High School.

"Reaching young people at critical times in their lives can make all the difference in their successful development as adults who can contribute to society," Edgar said. "These grants provide vital help for young people to stay in school, to postpone the starting of a family and to learn the skills necessary to find and hold a job."

Established in 1982, the Ounce of Prevention Fund is a public-private partnership that promotes the well-being of children and adolescents. The fund administers the Toward Teen Health program, which works toward improving preventive health services for students in poor neighborhoods. The program is funded by the Illinois Department of Public Aid, the Illinois Department of Public Health and the Chicago Board of Education, in addition to private donations.

At the school health centers, staff members counsel students to help them avoid unwanted pregnancies. In addition, they provide prenatal care for pregnant teens to reduce the incidence of low-birth-weight babies and work at keeping teenage parents in school.

DURING THE 1990-91 school year, more than 75 percent of the students at the three high schools were enrolled at one of the clinics. Program administrators said the birth rate for students enrolled at the clinics is half the rate of the communities where the clinics are located.

"The health centers aren't important just because we provide a dozen assorted medical services," wrote program director Saundra Lightfoot in the program's annual report. "They're important because of their connective role for students and the community. We really try to be part of a network of community services."

Sinai Family Health Centers provide each site with physician services at least three half-days per week. The school clinics are important because they offer comprehensive health services, said Climentene Jones, MD, medical director at Sinai and for the Toward Teen Health program.

"We see all the same problems you see in a regular physician's office – sore throats, asthma, sprained ankles. And we dispense medications," said Dr. Jones. "These kids are not used to getting comprehensive health care, generally. And because we are here at the schools, where the kids are, we are able to capture them."

FULL-TIME CLINIC STAFF includes a nurse practitioner acting as site manager, a social worker, a medical assistant serving as a link between students and the attending physician, and a secretary, who coordinates appointments and handles the clinic's paperwork.

"After some time, the kids do develop relationships with the clinic staff," Dr. Jones said. "Staff members listen to the kids when they talk; they get to know them and their problems."

Each clinic also employs a health educator who works mostly outside the clinic, providing classroom presentations on topics ranging from nutrition to self-esteem to AIDS. The health educators also conduct special programs at the clinics on such topics as parenting, AIDS awareness, and self-esteem and responsible behavior for young men.

After parents have enrolled students to receive health services, the teens may go to the clinic as needed, according to the *Parent's Guide to School-Based Health Centers*. At enrollment, parents must sign a consent form regarding which services their children may receive. All students receive first aid when needed.

"The kids can get whatever they need from us," said Dr. Jones. "The physical exam is an entree to other issues going on with them; we get them talking and we pick up on other types of problems they have. We don't leave off one aspect of their care. If you don't deal with all the issues these kids have, you are not treating the whole child." ■



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Federal lawmakers discuss system reform options

TOWN MEETING: U.S. Rep. Harris Fawell's constituents voiced their concerns about reform and learned about Republican-proposed alternatives. By Anna Brown



M. Candee

Rep. Fawell (left) and Sen. Coverdell support health system reform alternatives that include the use of medical IRAs as an incentive to help patients make wise health care decisions.

[NAPERVILLE] At a Veteran's Day town meeting at Edward Hospital in Naperville, three senators promised to pursue an alternative to the Clinton administration's health system reform legislation. The event was hosted by U.S. Rep. Harris Fawell (R-Clarendon Hills). U.S. Sens. Phil Gramm (R-Texas), Dan Coats (R-Indiana) and Paul Coverdell (R-Georgia) addressed an array of reform issues, including their concerns about an increase of governmental bureaucracy and the lack of realistic funding mechanisms in the Clinton bill.

The large turnout, composed mostly of Fawell's constituents, filled the hospital's auditorium and spilled over into adjoining rooms equipped with television monitors. Most responded favorably to the senators' ideas, which included the introduction of medical IRAs and refundable tax credits "to help people buy good health insurance," Gramm said.

"This is the most important decision that we will make this quarter century," Coverdell said. "A battle not engaged is lost. Each of you needs to engage this with your family, with your business and with the policy-makers in your community."

Their recommendations would leave the current health care system virtually unchanged, the senators said. However, they would include cost-control mechanisms and expand access to care by encouraging patient choice. For example, individuals might use their employer's insurance policy to purchase health care, use their share of the employer plan to join an HMO or a voluntary health alliance, or invest in a medical IRA. "If you like [your current health insurance plan] and if you are willing to pay the premium, we believe you ought to be able to keep your health insurance," Gramm said.

The senators also support making health insurance portable and ensuring that benefits cannot be denied because of a serious illness. "What good is health insurance if you don't have it when you need it?" Gramm said, noting that those are two areas of reform on which he and the president agree.

"In the short term, we can make benefits portable," Coverdell added. "We can make them permanent; we can deal with the administrative overload; we can deal with malpractice reform, antitrust reform – which will allow the sharing of high technology. We can do all of this quickly, and we can do it without raising a single tax dollar. When we will have done that, we will have taken uninsureds from 15 percent to under 3 percent. That's an incredible improvement in the system."

"My experience is essentially that human beings don't change their behavior unless they have incentive to change," Coats said, explaining his support for encouraging healthy lifestyle choices through the use of medical IRAs. "We need to provide financial incentives for people to make decisions about their health. If they can save their own money by making correct health care decisions, they're going to change their behavior."

Coats also stressed the need for medical malpractice reform, especially a cap on noneconomic damages. He said a cap established several years ago in Indiana is working, and he cited cases in which Illinois physicians have moved to Indiana to avoid the litigious climate and high cost of liability insurance here.

"Everybody belongs to various interest groups," Coats said. "And while it's going to be very difficult to coordinate it all, everybody has a stake in reform. And if we energize all of these institutions that are wedded to the fundamental principles of our country, it will make a difference." ■

Study compares hospital leaders' roles, functions

[CHICAGO] The role of hospital leaders was examined in a recent study conducted by the AMA, the American College of Healthcare Executives, the American Hospital Association and Ernst & Young. The study compared the perceived roles of hospital board chairmen, CEOs and medical staff presidents with the actual functions these leaders perform, according to ACHE. Researchers also looked at how effectively these leaders work together.

During the study, 1,423 respondents from 1,197 hospitals were asked what they considered their main responsibility. Participants in each group were told how members of the other groups answered and were asked whether they agreed with those perceptions.

The study found that although more than two-thirds of board chairmen thought that one of their primary roles was developing the hospital's strategic plan, only half of the CEOs and medical staff presidents agreed. Further, only 25 percent of the CEOs said their job included presenting medical staff interests to the board, but more than half of the board chairmen and 40 percent of the medical staff presidents saw this as a CEO's key role. About half of all participants said the medical staff president's job is to represent the board to the medical staff.

The second phase of the study is slated to begin early next year, according to ACHE. ■

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

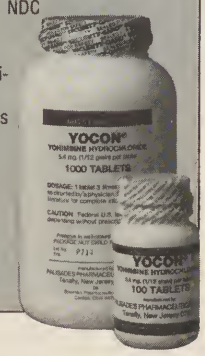
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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EDITORIAL

Some things never change

The more things change, the more they remain the same. If you ever doubted the wisdom of that saying, read the following excerpt from the July 1939 issue of *Illinois Medicine*'s predecessor, the *Illinois Medical Journal.*

Chiefly, state medicine's sourest fruits would seem to be:

1. Lowered morale on the part of the profession;
2. Inadequate service towards the clientele due to bureaucratic red tape, inadequate recompense and inadequate study and diagnosis of individual cases eventuating from a mass clientele;
3. Too much lay control of scientific practice;
4. Too political and too unscientific a control;
5. Too much taxation for results to taxpayers;
6. Government interference with affairs of nature involved to be regimented under human mechanistics;
7. Development of a group of maladies imaginary or of malingering citizens who find it more profitable to ail at the expense of the state than to follow the normal lines of industry;
8. No reduction in death nor increase in birth rate;
9. Analogous ethical debauchery of the apothecaries and loss of profit to them as well as to dentists;
10. General chaos of method and confusion of ideals with no profit except to uninformed lay supervisors and inspectors.

The physicians of the United States will do well in the coming year to study this both from the point of the profession and the public, but also to the public pocketbook, which is after all, only the heart and wealth of the nation.

Just think, this list was compiled and the excerpt published before Medicaid, OSHA, CLIA, utilization review, malpractice crises, double-digit inflation, proliferating paperwork and Hillary Rodham Clinton. And even though a stagnant birth rate is no longer a problem, most of the other items still apply 54 years later. Physicians' lowered morale. Inadequate emphasis on individual cases. Bureaucratic red tape. Excessive unscientific control. Government interference.

The more things change, ...

PRESIDENT'S LETTER

Reforming the system – for everyone



By Arthur R. Traugott, MD

With health system reform so prominent on today's public agenda, we have an opportunity like never before to build a health care system that works for everyone. Because of the magnitude of potential reform, many organizations are identifying problems and proposing solutions. However, we need to make sure that all changes have been well-considered and do not compromise patient care.

A recent series in the *Chicago Tribune* pointed out that Medicaid is a deeply troubled fiscal program. I believe its problems result from overregulation by remote forces in Washington. The warning threaded throughout the series was that a reformed health care system laden too heavily with governmental control will push all of us toward Medicaid's current situation rather than raise those in need to the level of care most Americans expect for themselves and their families.

Regarding solutions to Medicaid problems, ISMS rejects measures that could institutionalize a "second-class" system for the indigent. In our ISMS Health Care Reform Plan, we call for Medicaid recipients to be assimilated into a high-quality health care system by providing them with the same guaranteed benefits plan we seek for everyone in our society.

In what Blue Cross and Blue Shield of Illinois is presenting as a reform-related move, the insurer announced Nov. 9 a major initiative to mandate practice guidelines for Illinois physicians participating in the company's new preferred specialist referral network. As part of its contractual terms, BCBSI is requiring some 1,300 Illinois cardiologists, oncologists and general and orthopedic surgeons to agree to compliance with its guidelines covering 14 medical procedures. ISMS is greatly concerned about unilateral insurance company edicts that prescribe medical practice in Illinois. Specifically, our concern is that BCBSI will consider its practice guidelines the "be all and end all" in the practice of medicine.

The issue, again, is quality of care. If practice guidelines are imposed by an insurer, the bottom line may be a stronger consideration than the provision of quality patient care.

The issue, again, is quality of care. If practice guidelines are imposed by an insurer, the bottom line may be a stronger consideration than the provision of quality patient care. Look at what has happened with utilization review and other standards imposed by third-party payers. Insurers sometimes pressure physicians to prescribe treatment and hospital stays that are less than ideal for particular patients and their specific needs.

In addition, various insurance companies might use different practice guidelines, resulting in an inconsistent standard of care. And, if practice guidelines are the final word on how to treat patients, can physicians still use their clinical judgment to vary from those guidelines in treating individual patients? If so, how much variation is allowed?

ISMS is reviewing options to ensure that practice guidelines do not harm patient care or the state's malpractice climate.

"Reforms" that threaten the quality of health care are injurious to our patients and aren't really reform at all.



The Wall Street Journal /Cartoon Features Syndicate.

"I was hoping I could choose my own doctor."

LETTERS

Clinton proposal includes fantasy

The Clinton health plan consists of smoke and mirrors. When the Clintons talk about their plan, they accentuate the positive aspects but purposely neglect to mention its downside.

They keep stressing that there are 37 million people without health insurance, but that total includes millions of young healthy people who elect not to purchase health insurance. It also includes people who are temporarily employed.

The Clintons assure the public freedom to choose their own physicians, but on inspection of the health plan, one learns that the cost of fee-for-service coverage would be prohibitive to the average person or family.

In addition, the Clintons tout preventive care. They magnanimously offer mammograms every two years for women over 50 and provide for Pap smears every three years for all women. Currently, the medical community recommends mammograms and Pap smears yearly. Do the Clintons believe that cancer cells will take a holiday for two or three years by government edict?

With this health plan, patients can expect to lose their personal relationship with their physicians. Those who have served in the military will remember sick call, where you were just another face. Before you could describe your complaint, you were "diagnosed," given some medicine and rushed out of the dispensary. With the proposed health plan, it will be deja vu. Individuals will be issued a health care security card to be presented when medical care is required. But they won't be patients by name; they will be patients by number.

President Clinton is now touring the United States hawking his health care plan in an effort to convince the populace of its value. This show is reminiscent of the old-time road show in which the medicine man traveled from town to town attracting townspeople and farmers with magic and sleight of hand. After he caught their attention, he sold them snake oil from the back of his wagon. Sound familiar?

By selecting the Clintons' health care plan, all of us will sacrifice our right to freedom of choice in health care. And after all, our patients' health and very lives are at stake.

– B.B. Neuchiller, MD
Woodstock

Lead testing questioned

We, as practicing physicians, are being pressured to order only necessary tests and effective treatments. Now, we are treated to the unscientific findings of the Illinois Department of Public Health concerning lead testing.

First, the department redefined abnormal lead levels by lowering the amount of lead it considers acceptable. Then, the whole state was lumped into one law requiring that all children be tested, whether they live in Cabrini Green, Streator or an upscale neighborhood in Naperville.

After running out of free testing in Streator, officials decided it wasn't so necessary to get the testing after all.

I would like to see the statistics for Livingston and LaSalle counties. How much did it cost in those counties to find a case of high lead – that is, more than 25 micrograms per deciliter? How much did it cost to find a case of more than 10 micrograms in those two counties?

I might add that if the standards were lowered to one or two micrograms, officials would find even more cases and could really feel good about stamping out disease. What nonsense!

In fact, the state of Massachusetts – not noted for its conservative treatment of wild-eyed ideas – turned this program down.

– James E. Gottemoller, MD
Streator

Editor's note: Effective as of Jan. 1, 1993, the ISMS-supported Illinois Childhood Lead Prevention Act mandates that all children under 7 be tested for lead poisoning before they enter day care, preschool or kindergarten. The state lowered its acceptable blood lead level for children from 25 micrograms per deciliter to 10 micrograms per deciliter based on recommendations from the U.S. Centers for Disease Control and Prevention, which said that children in middle- and upper-class homes are also at risk for lead poisoning.

GUEST EDITORIAL

Clinton bill raises questions

By Joan Beck

With its 1,324 pages of legislative legalese, President Clinton's new Health Security Act may be the most complicated bill ever introduced in Congress.

Even so, it leaves a slew of questions unanswered about what it will do to our lives, our health, our taxes, our economy and our national debt.

For starters, here's a sampling:

1. Can a 1,342-page law be understandable not only to members of Congress who must pass it, but to the bureaucrats who must administer it and to the public whose lives will depend on it? Or is the administration creating a new IRS-type monstrosity that will make today's health care mess look like Tiddlywinks?
2. Conventional wisdom holds that runaway health care costs are due in large part to economic incentives for physicians and hospitals to treat patients more than necessary. But isn't there a danger the cost-containing incentives in the Clinton plan will make it profitable to undertreat patients – with some dangerous consequences?
3. How can taxpayers believe the cost estimates in the Clinton plan are reasonably correct? The federal government, after all, has been horrendously wrong in costing out other health care plans. For example, the End-Stage Renal Disease program that pays for kidney dialysis was projected to cost $250 million annually in 1977, five years after its start-up; in 1991, the bill came to $6.6 billion.
4. What confidence can we have in Clinton's assertions that more-efficient administration will cut costs enough to pay for much of the expanded coverage? As Vice President Al Gore pointed out several weeks ago, federal regulations generate tons of expensive, unnecessary paperwork. Will the health plan do better, even if it is run by the states? Medicaid – at least in Illinois – is so poorly managed that cheating, over-billing, unnecessary care and other abuses are rampant and unlikely to be weeded out.
5. Won't the requirement that employers provide health insurance for workers carry built-in incentives for small businesses to reduce their payrolls and hesitate to take on new hires – even with the subsidies the Clinton plan promises? Since small businesses generate a majority of new jobs, won't this increase the rate of unemployment?
6. If a big majority of Americans are satisfied with their current health care, why should they take on the risks and complications of the Clinton plan, especially when 40 percent of people will be paying more (some will get lower deductibles) and 15 percent will pay more and get less coverage?
7. How can using $140 billion in cuts in future Medicare spending to finance the health care plan be justified when Medicare reimbursements are already so low that some elderly people have trouble getting care? Why should those over 65 have to stay in Medicare when it will provide fewer benefits than health plans for younger people?
8. Who is going to pay for health care for the nation's 3.2 million illegal immigrants, for whom the Clinton plan provides only an inadequate $1 billion a year for emergency treatment? What will happen to public health if large numbers of undocumented people can't get care for contagious diseases, pregnancy and other medical problems?
9. Despite the lip service the Clinton administration – yielding to pressures and criticism – now gives to plans allowing people to choose their doctors and hospitals and pay on a fee-for-service basis, is there any certainty such freedom can be preserved? Many analysts predict most doctors will be forced out of private practice and that choice will be priced out of existence and will soon disappear.
10. What Clinton is proposing is actually a gigantic, new entitlement program, like those that now make it impossible to control the federal budget, the deficit or the national debt. Shouldn't Clinton – and critics such as Ross Perot – be more concerned about the deficit dangers of the health care plan or the new taxes it may require?
11. How will cost controls on insurance premiums, fee schedules, budget caps and global budget requirements actually work? What the administration is now proposing – after backing down some under fire – is essentially price controls. And price controls are ineffective in the long term, create shortages and could lead to rationing.
12. What will be the effect of the squeeze on high drug prices the Clinton plan calls for? Will what is essentially price controls cut into the ability of pharmaceutical companies to carry on research and develop new medications that could reduce the cost and improve the outcome of treating many illnesses?
13. Isn't it unrealistic – and dangerous – to try to hold health care costs to the rate of inflation, as Clinton proposes, when the aging population with their increased needs for care is growing rapidly, when new technology can help cure illnesses and relieve suffering, and demands are escalating for better treatments for such diseases as breast cancer and AIDS?
14. How can we be sure that the heavy hand of government won't stifle and do harm to what is now the best medical care in the world and that medical innovation and discovery will still flourish?
15. Is there really an emergency in health care that justifies such a sweeping new power grab by the federal government and such incalculable risks to the nation's economy? Can't problems in the current system be fixed by clearly targeted, evolutionary improvements?

Congress is expected to debate for at least several months about the Clinton plan, as it should with legislation that will affect all of us so intimately and will be so disruptive of a major economic sector. At the very least, voters should insist on creditable answers to questions like these.

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ISMIE Update

Nominations sought for ISMIE board

PAGE 10

Don't forget your invisible office staff

PAGE 10

Without caps, forget reform

By David McIntosh

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Editor's note: Although the following piece was originally published before the Clinton bill was sent to Congress, the information is still relevant.

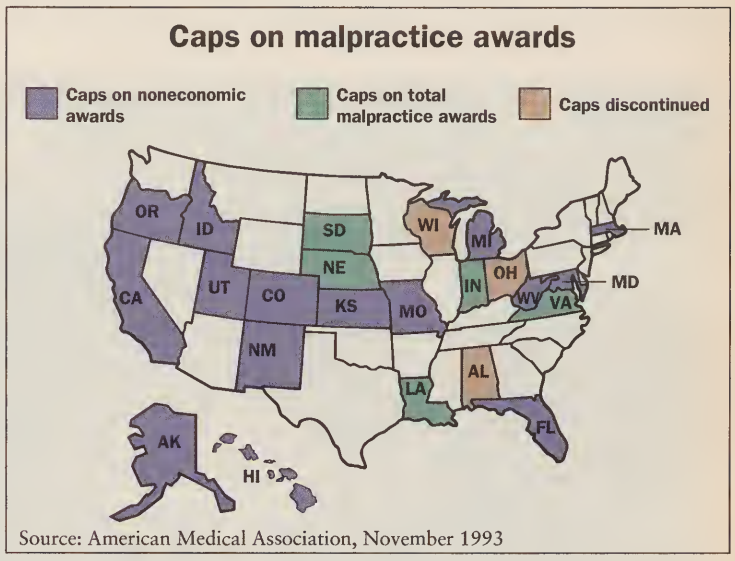
One of the basic tricks of a con artist is to distract you by giving you something that appears to be valuable – which it never is – while taking from you something worth a great deal more.

Congress will soon begin debating whether President Clinton's health-care plan is worth the costs, but there can be no doubt that the president's plan will steal from us something very valuable indeed: a chance to reform our nation's costly medical malpractice system.

The biggest omission is the president's apparent decision not to place a cap on malpractice awards. Instead, he is expected to propose a watered-down package of reforms that any self-respecting con artist would recognize as a poorly executed shell game.

The current system encourages lawyers to take routine cases and try to convince juries that the doctor's insurance company should not only pay for the actual harm done to the patient but also pay millions of dollars more for "pain and suffering." The lawyer then takes as his fee up to 33% of the money. Because the lawyer gets a high percentage of the award, he has a big incentive to persuade the jury to give as much as possible. And because the jury doesn't pay the award itself, there is no reason that they shouldn't be moved by the pleas of the plaintiff's attorney.

As has been well documented on these pages, awards have skyrocketed over the years, driving up the cost of malpractice insurance. And the public suffers, because the process causes increases in health insurance premiums for the rest of us. The situation has become so bad that doctors in high-risk practices are leaving states that have the highest malpractice insurance costs. For example, in Florida – the state with the highest malpractice insurance rates – expectant mothers sometimes have to travel out of state to give birth, because the high insurance costs have caused a severe shortage of obstetricians.



Source: American Medical Association, November 1993

During the past two decades, several states have capped malpractice awards. In 1976, Indiana instituted reforms that should be a model for President Clinton. Under the leadership of Gov. Otis Bowen, malpractice awards were capped at $500,000 (which has since been raised to $750,000). Private malpractice insurers pay for any damages up to $100,000. If the doctor is found to be liable for more, the rest is paid for by a special state-run fund, funded by doctors. Indiana also limits the amount lawyers can take as their cut: 15% of any amount

(Continued on page 11)

MALPRACTICE ROUNDUP

Exam results inadmissible in suit

A Missouri appeals court ruled that a physician's failure to pass written board certification tests is not admissible evidence in a negligence suit.

Medical Malpractice Law & Strategy reported that the plaintiff's counsel tried to admit evidence that the defending physician had failed the American College of Surgeons' board certification exams 10 times. The plaintiff contended the evidence was relevant to call into question the testimony of the defendant as an expert witness and to link his inability to pass medical exams to his alleged negligence.

The trial court and the appeals court granted the defendant's motion prohibiting introduction of evidence regarding the exam failures. The appeals court ruled that the defendant's testimony about his qualifications as an expert addressed only his education, training, professional experience and license to practice medicine. The defendant had testified that he was not board-certified. The court ruling also stated that a physician's inability to pass written certification and licensing exams is irrelevant to his or her alleged negligence. ■

Physician sues drug maker for damaged reputation

As reported in *Medical Malpractice Law & Strategy*, a Washington state physician was awarded $1.1 million against a pharmaceutical manufacturer for damage to the doctor's professional reputation. The physician had prescribed a drug for a 2-year-old patient who later suffered seizures, resulting in permanent brain damage.

Five years before the physician prescribed the drug, its manufacturer sent a letter to a few physicians informing them that the drug was "capricious." The letter said the company knew the drug represented a life-threatening risk for children with viral infections. In addition, an internal company memorandum, issued before the physician prescribed the drug, noted a dramatic increase in reports of serious toxicity and referred to the recommended dosage as a "significant mistake." The memo also indicated that physicians may not be aware of the "alarming increase in adverse reactions such as seizures, permanent brain damage and death."

The patient's parents sued the physician for malpractice, and in turn, the physician sued the drug maker, claiming that the Washington Consumer Protection Act had been violated and his reputation damaged. The jury returned a verdict for the physician, finding that the company engaged in an unfair or deceptive act by failing to disclose the toxicity of its drug. ■

Manufacturers face negligence suit

The *Chicago Tribune* reported that after an estimated 10,000 hemophiliacs were infected with HIV from contaminated blood products, a federal class-action suit claiming negligence was filed in September against four medical products companies.

According to the suit, the manufacturers continued marketing their blood-clotting products after July 1982 even though they knew the products were contaminated with HIV. The suit alleges that after AIDS cases were reported in the United States in 1980, the manufacturers "knew or should have known" about hemophiliacs' risk of contracting HIV from using these products, because such products were known to transmit other viruses such as hepatitis. The plaintiffs are seeking unspecified damages. ■

Disciplined physicians may be jailed

Medical Liability Advisory Service reported that physicians may have a greater chance of facing criminal charges if prosecutors think state disciplinary boards do not provide adequate punishment for allegedly poor treatment.

A New York physician was sentenced to 52 weekends in jail after a jury found him guilty of neglecting and recklessly endangering the life of a 78-year-old patient. The physician was charged with failing to quickly transfer the woman from her nursing home to the hospital after he mistook her dialysis catheter for a feeding tube. An appellate judge ruled that the physician need not begin serving his sentence until his appeal is completed. ■

Don't forget your invisible office staff

RISK MANAGEMENT: Physicians should supervise their answering services just as they would their in-office employees.

Reprinted with permission from The Letter, *a publication of the Louisiana Medical Mutual Insurance Company, Vol. 11, No. 4, July/August 1993.*

Your answering service could be the stepping-stone to an unexpected professional liability complaint. We have noticed an increase in the number of claims that may have been precipitated by the physician's answering service. Particular problems were noted in the areas of failure to notify a physician of a patient's needs in a timely manner and poor documentation of a conversation that delayed response by a physician.

An answering service should be considered your "invisible" office staff and should therefore be counseled to respond to patient inquiries in accordance with your established office guidelines and procedures. In short, the answering service should not be another line of interference that patients must go through to get to their physician. Rather, the answering service should facilitate communication between the physician and patients during the hours the office is closed.

To assist you in establishing a proper protocol for your answering service, we would like to offer the following recommendations:

1. Test your answering service by calling it at an unusual hour, perhaps 2 a.m., to determine the amount of time taken to answer your call. You should take note of the manner and quality of the response and whether the response is the same for both your male and female patients.

> *You should demand the same level of courtesy, respect and attentiveness to detail that you demand of your staff.*

2. Be certain that you receive a copy of your "test" call when you arrive at your office. If you do not receive a copy of your test call, you may not be receiving copies of all of your other calls.
3. The answering service should always refer to a written protocol that establishes and outlines your requirements.
4. You should review and modify as needed your written protocol on at least an annual basis.
5. Historically, answering services have high employee turnover. Therefore, be certain that your service properly trains all new employees according to your requirements.
6. Do not allow your service to determine whether an immediate consultation is required.
7. You should require your service to obtain the names of all callers even if the caller decided to phone you during normal office hours. The name and number can then be referred to your office staff for follow-up.
8. Copies of all after-hours calls should be placed in patients' records only after you have seen and initialed each call and determined the appropriate course of action.
9. You should retain a log of your answering service messages as well as your regular office log. These records should be kept in a safe place for at least six years.
10. Pre-screening messages used by the service are useful in cutting down on the number of nonemergency calls. One recent survey indicated a pre-screening message advising the office was closed, its regular hours and another number for emergency calls cut down calls by as much as 60 percent. This allows the answering service and physician to concentrate on the patient in a genuine crisis.
11. If your answering service is dispatching messages to you through a beeper or pager, be sure it is instructing patients to call back if they are not contacted by you within a specified time frame. If you don't delete messages received on your beeper or pager, you can review them when you arrive at your office to assist in documenting the appropriate information.

Your answering service is an extension of your medical practice and you should supervise this service in the same manner that you supervise your regular office staff. You should demand the same level of courtesy, respect and attentiveness to detail that you demand of your staff. Any deviation from your standards may cripple your ability to professionally respond to your patients' needs. ■



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Nominations sought for ISMIE board

The Exchange will hold its annual meeting on Wednesday, April 20, 1994, at the Oak Brook Hills Hotel in Oak Brook. Elections for the ISMIE Board of Governors will be held during the meeting. Board members are elected by a majority vote of the members represented at the annual meeting in person or by proxy.

The Board of Governors exercises general supervision over the finances of the Exchange and its operations, and establishes all policies governing the proper transaction and conduct of the business and affairs of ISMIE.

Any Exchange member interested in serving on the Board of Governors should send a statement of interest, accompanied by a current curriculum vitae, to ISMIE Board Chairman Harold L. Jensen, MD, c/o Illinois State Medical Inter-Insurance Exchange, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. Each candidacy must be seconded in writing by two other ISMIE policyholders. Each insured may second up to seven separate nominations. All curriculum vitaes and written nomination seconds must be received at the ISMIE offices on or before Jan. 4, 1994.

All candidate submissions will be reviewed by the Exchange Nominating Committee, which will then provide a recommended slate of nominees. Candidates who are not slated by the committee will be notified, and they may elect to be placed on the ballot as independent candidates. ■

Forget reform

(Continued from page 9)

over $100,000.

Rather than place a cap on damages – an approach we *know* will work – the president has floated a watered-down version of reform, which studies show will do little or nothing to help control costs. The plan now floating in Mr. Clinton's latest revised, amended and reconstituted trial balloon would do two things, neither particularly effective.

First, it would institute what lawyers call "the collateral source rule." This requires them to seek payment first from their client's own insurance policy, and then, if that policy does not cover the damages, dip into the doctor's malpractice policy. This seems eminently fair, but studies have shown that it has little effect in bringing down the cost of malpractice insurance.

Second, the president hinted he might want to cap attorneys' fees, too. But not at Indiana's generous 15%, or even at 25%. Showing much more generosity to attorneys than he has shown to taxpayers, the president will cap attorneys' fees at 33%. And, don't be confused by the howls of pain from the trial attorneys' lobby – if there has to be a cap, they could not be happier than with Mr. Clinton's proposal: It is exactly what most lawyers charge anyway.

By backing away from real caps, Mr. Clinton is ignoring one of the most important means of controlling costs without reducing the quality of our health care.

By backing away from real caps, Mr. Clinton is ignoring one of the most important means of controlling costs without reducing the quality of our health care. Studies show that of all the reforms enacted in the 1970s and 1980s, damage caps were the *only* effective means of reducing both the number and size of malpractice claims.

The Hudson Institute Competitiveness Center's preliminary review of 1993 data confirms that this trend is reflected in the typical premium paid for malpractice insurance. (States that cap all damages have dramatically lower premiums for medical malpractice. Interestingly, states such as California where only the "pain and suffering" portion of the damages is capped, do not seem to have significantly lower averages – although the rates of increase in those states have slowed.)

The Indiana reforms have worked wonders. Indiana has the lowest premium of all: typically, $4,350 a year. Compare this to Florida, where doctors typically pay $73,000, and the national average, which is $16,500.

More important, patients who suffer severe losses actually receive more money in Indiana than they do in surrounding states. A study by several Indiana University Law School professors (Eleanor Keaney, et al.) compared the average amount paid to patients in Indiana to the amount paid in Michigan and Ohio. Until recently, these states had neither capped damages nor limited attorneys' fees, yet their legal systems paid out *fewer* dollars to severely injured patients. This is because in those states, the attorneys snap off a bigger bite of the award for themselves. By contrast, in Indiana insurers often will settle cases out of court quickly, minimizing legal costs and ensuring that more of the reward goes to the victim.

It's no surprise that Mr. Clinton has failed to embrace true malpractice reform. During the presidential campaign, trial lawyers raised millions of dollars for him, promising their fellow attorneys that they would have a direct line to the president and would make sure that any serious legal reform would be killed off by the boss himself. This is one promise the president is keeping.

The taxpayers deserve better than this. Congress should reject the president's plan and enact reforms that cut costs and pay more to injured patients. Insurance premiums would go down; patients would pay less for better health care; and people who were injured through no fault of their own would receive higher awards in a fairer and more efficient legal system.

If Congress did that, everyone would be better off. Except maybe the trial lawyers. ■

McIntosh is a fellow for domestic affairs at the Competitiveness Center of Hudson Institute in Indianapolis. He was executive director of Vice President Quayle's Council on Competitiveness.



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Bringing the community together in rural Illinois

Because of a state senator's efforts, a local clinic is providing needed medical service.

BY ANNA BROWN

Everyone at the Rea Clinic in Christopher is on a first-name basis with the clinic's founder, Sen. Jim Rea (D-Christopher). The senator was born and reared in Christopher, and when the community was threatened with the closing of the local hospital, Rea spearheaded a program to develop the health center.

The 14-year-old community clinic in Franklin County, in rural southern Illinois, accommodates the medical needs of 14,000 local patients who might otherwise be forced to travel miles to find comprehensive primary care. Although much of the patient population is indigent, the clinic serves anyone who makes an appointment. The health center is bustling with providers, including a pediatrician, an internist, two family physicians, a general practitioner, nurses, dentists, a podiatrist and a physician assistant.

"Today there is more of an interest in what we're doing, and the clinic has served as a model – particularly for medically underserved areas of the state, whether rural or urban," Rea explained. Community clinics must modify their services according to local needs, he noted, adding that to provide good service, clinics must also have strong ties to area organizations and businesses. The not-for-profit clinic is headed by a diverse, 11-member, community-based board, said Rea, who chaired that board until he was elected to the General Assembly in 1979.

"WHAT'S UNIQUE about the clinic, from a physician's perspective, is that we are committed to providing service to all generations in life, from prenatal care to patients in nursing homes," Rea said. Many patients are elderly and have returned to southern Illinois to retire after having worked elsewhere, he added. "We provide comprehensive, uninterrupted treatment for patients who have nowhere else to go. This is real primary care."

"This clinic gives me the opportunity to practice primary, secondary and tertiary care," said Schlomo Hellerstein, MD, an internist at the Rea Clinic. "I enjoy all aspects of medicine. And the human side is still important here. I know my patients very well. Anyone who comes in here gets treatment, no questions asked. We give patients continuous care."

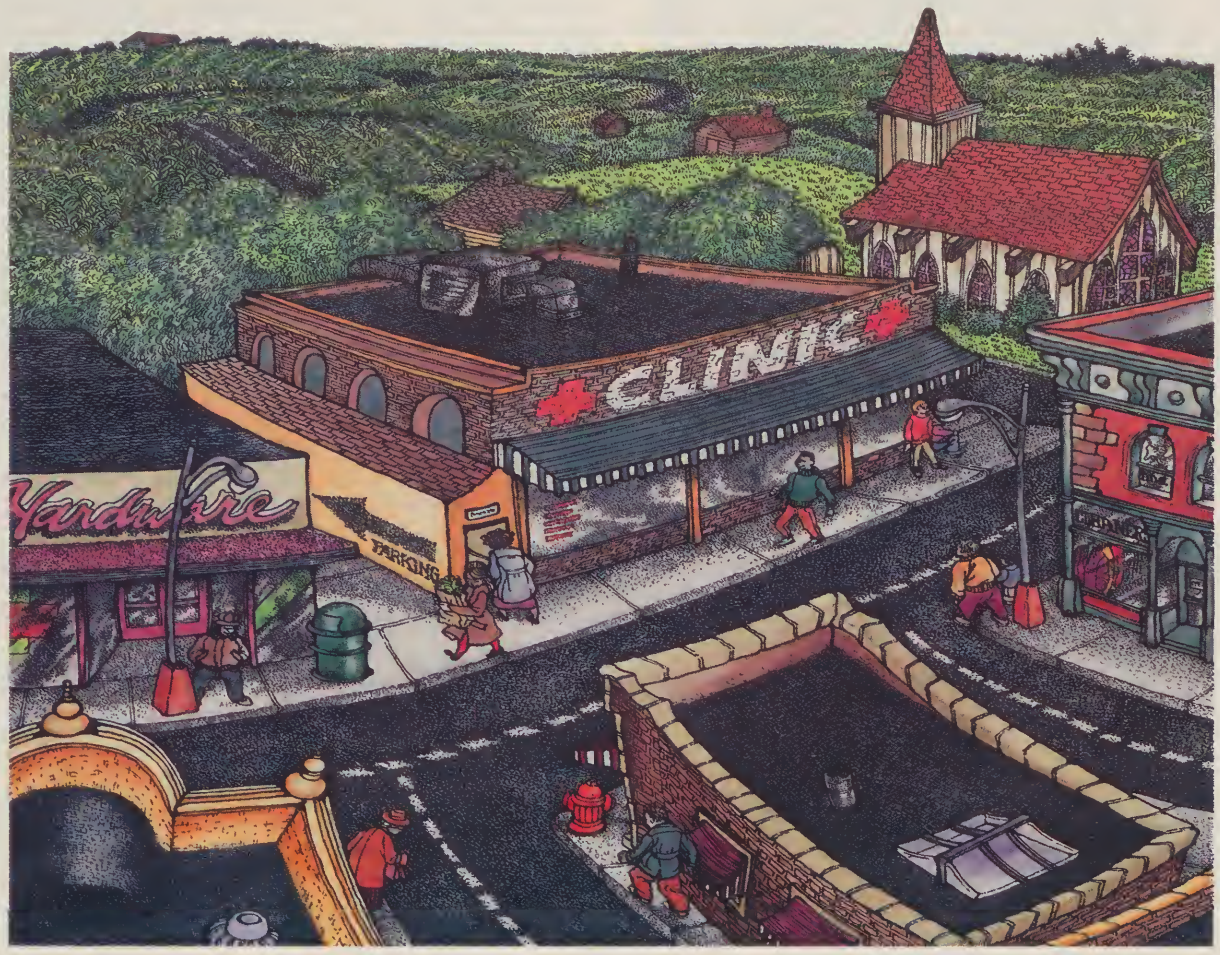
There are 600 community health centers throughout the United States, including 26 in Illinois, said the clinic's executive director, Kim Battaglia. Most of the state's clinics are in the Chicago area, and many more are needed in Illinois' rural areas, she added. Rea predicted that under health system reform, "we will see strengthening of these types of facilities."

ALTHOUGH THE CLINIC serves many indigent patients, it is not a free clinic, said Battaglia. Federal grants from the U.S. Department of Health and Human Services provide 30 percent of the clinic's operational funding. The rest is provided through payment for patient care, including reimbursement from the state for Medicaid patients, she said.

"Like any other provider, we bill everyone," Battaglia said, adding that the clinic negotiates Medicaid reimbursement rates with the state. "In Franklin County, 21 percent of people age 21 and younger are on Medicaid." Patients who earn 185 percent of the poverty level are eligible for sliding scale fees at the clinic. Others may pay no fee, but "we don't have a lot who qualify for no payment," she explained.

Before the clinic was established, Christopher was served by a hospital that had been converted from an

EXPANDED ACCESS



Susan Wise

old school building, Rea said. "Each year we began to have more and more difficulty meeting safety codes. We could get a license to operate for only one year at a time. It finally became obvious that the license was no longer going to be extended. There was great concern that we would lose our physicians."

The physicians did, in fact, leave Christopher. That's when Rea formed a group to apply for federal grants for a primary health care facility.

"When we started out, people were skeptical because they used to have a hospital," Rea said. "We had some bad PR problems initially. We went to the local newspaper and asked them to report everything we were doing, so it was all above table." The group eventually obtained funds to build a facility, which became one of the first federally funded health clinics in the country, he noted.

"We felt that if we could set up a primary health care clinic, we would be able to attract doctors to the area," Rea continued. "If we provided the facility and equipment and did the billing, this would be a great incentive to physicians. Overall, with aggressive staff recruitment, this paid off."

The clinic was expanded in 1981 when administrative offices were added. And since filing space is tight, further expansion is planned, Battaglia said. In addition to physicians' offices, examination rooms, and a laboratory and X-ray room, the clinic boasts an emergency treatment room. Here, patients can often avoid hospital admissions – for instance, by receiving an IV as part of treatment for the flu, Battaglia said. Treatment room physicians have also taken bone marrow samples, defibrillated patients and delivered a baby, she added.

"A treatment room is very important to a community health clinic," Rea said. "When the community lost the hospital, people were very concerned about emergency services."

Many rural hospitals aren't regularly staffed with ER doctors; instead, physicians are available on-call, Battaglia said. "People don't like that. They want to be brought here because they know the doctor's here."

REA, WHO IS a member of the Senate Public Health and Welfare Committee, educates other legislators about community health clinics and the need to expand access to medical care in underserved rural areas. "There are a lot of state legislators who have no idea what a community health center is," Battaglia said. "Jim has been very helpful in trying to get a lot of those people down here. It's hard to vote favorably for something you have never seen," she continued, explaining that legislators often consider bills that deal with Medicaid reimbursement rates or other issues related to community clinics.

"Every person I've brought here couldn't visualize – never anticipated – what was here until they actually got here," Rea said. "They think it's a poor man's clinic, but this is run like a very sophisticated medical facility," Battaglia added.

In addition, Battaglia said it's difficult to attract industry to a community without medical services. "It's one of the first things they look for: Can you take care of their employees?"

According to Rea, the major benefit of his namesake clinic is that it provides health care beyond the local community. "It also provides care to people who cannot get it in other places that don't accept Medicaid patients. It means a lot to the economy of the community as well." ■



Carla Sommerfeld

CAROL FORNEY, a secretary in the Exchange's Claims Division, received the ISMS November Employee of the Month award in recognition of her commitment to physician-first service.

Sepsis infections cost patients $10.6 billion

[BALTIMORE] The incidence of sepsis increased almost 7 percent in 1992, costing the nation $10.6 billion, according to national hospital data compiled by HCIA Inc., a health care information company. Overall, sepsis infections increased projected U.S. hospital bills for the disease by 12 percent, slightly more than the 1992 health care inflation rate, HCIA said.

Sepsis is a systemic infection that occurs when pathogens from a localized infection or injury spread through a patient's bloodstream to the entire body. Treatment is costly, and the infection is often fatal, according to HCIA.

"The growing number of sepsis patients is partially the result of more and better health care," said Janet Young-Hasler, MD, of HCIA. "We are now able to keep patients alive who, in previous years, would have died. As a result, the immune systems of many of these patients have been compromised by treatment or underlying disease, which makes them more susceptible to these types of infections." The increased use of urinary, arterial and venous catheters also makes patients more vulnerable to sepsis, Dr. Young-Hasler added. ■

Officials condemn gun violence

FORUM: Community leaders suggest a public health approach to combat handgun injuries. By Gina Kimmey

[CHICAGO] At the second in a series of forums on women's health and the environment, gun manufacturers were criticized Nov. 8 for targeting their latest marketing efforts at women. Speakers at the program, sponsored by the Women's Issues Network, condemned the firearms industry and the National Rifle Association for relying on fear tactics and emotionalism in their "Refuse to be a victim" advertising campaign.

Forum participants argued that the ads ignore basic facts, such as those published in an Oct. 7 *New England Journal of Medicine* article stating that keeping a handgun in a home nearly triples the chance that someone will be killed there. Speakers said death and injuries from guns have reached epidemic proportions.

"Some people argue that this is not an epidemic; it's a crime problem. But I'm here to tell you that what makes an epidemic is the body count," said Katherine Kaufer Christoffel, MD, a Chicago pediatrician and a spokesperson on firearms issues for the American Academy of Pediatrics. "And by body counting, this is an epidemic. As a matter of fact, it's one of the worst we have ever experienced."

She cited statistics showing that in 1952, at the peak of the polio epidemic, 3,145 people died from the disease. In 1991, 38,000 people died from gun injuries, including more than 5,000 children and adolescents, Dr. Christoffel said. "That makes this epidemic 10 times the size of polio. It has gotten so bad, that firearms deaths actually outnumber natural-causes deaths in children and teen-agers."

By considering gun violence a public health problem, the focus of the gun-control debate shifts to death, disability and societal cost, rather than civil liberties, crime and manufacturers, she added. "Public health also gives us an agenda to follow. Policy flows from science. We protect the many at risk, not just those who are hurt, and we measure our success in outcomes – number of bodies, number of disabled, number of hospitalizations, money spent on hospital care. We have measurable outcomes by which to gauge our success."

Dr. Christoffel said approaching gun violence as a public health issue also creates a sense of purpose for individuals and groups. This evokes leadership from the public sector, making it easier for legislators to act.

One such lawmaker is state Rep. Barbara Flynn Currie (D-Chicago). A long-time gun-control proponent, Currie said there is no question that gun violence is a major public health threat.

"Why isn't there any action? It's not because we haven't tried," Currie said. "We are imaginative people, we gun-control proponents in Springfield. And we pull out of our pockets at a moment's notice a variety of measures, each of them designed in one way or another to help stem the violence."

Currie said a number of measures have been introduced in the General Assembly, including several that would have banned the sale of handguns and the sale and possession of military-style assault weapons, and required all handguns to have safety trigger locks. Although some gun control measures have passed the Illinois Senate, none have emerged from the Illinois House. Gun-control proponents must contact their legislators and express their views if legislation is to be enacted, Currie added.

ISMS House of Delegates policy supports educational efforts regarding the dangers of handguns, owner liability laws and stricter licensing regulations.

"Those who support the proliferation of guns have done a very good job of marketing the fear that many people feel about violence," said Joseph Gardner, organizer of Target Hope, an anti-crime coalition currently developing proposals to address gun violence. "Those of us who are committed to meaningful and reasonable gun control have been outmaneuvered by our opponents."

Proponents must mobilize and involve key constituencies – such as health care professionals, the insurance industry, businesspeople and community activists – that may not have been very involved in this whole issue, Gardner said. ■

Editor's Note: The next issue of Illinois Medicine *will cover the Chicago Medical Society's new anti-handgun resolution.*

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Practice guidelines

(Continued from page 1)

ical decision," he continued. "Physicians cannot and should not be expected to limit the treatment options for their patients in the name of cookbook medicine."

The contract provisions mandating physician compliance with the guidelines are scheduled to go into effect Jan. 1. Physicians who repeatedly deviate from the BCBSI-established guidelines without cause will be asked to leave the network, according to BCBSI.

"The potential effect of this mandate on patient care is unknown," Dr. Freidheim said, adding that the Society is concerned about how the insurer will handle individual cases in which a physician's clinical judgment falls outside the guidelines. "Are physicians expected to blindly follow the guidelines, possibly jeopardizing patient care, or follow their instincts as highly trained specialists, only to face expulsion from the network? We are also unsure about the potential impact of this new policy on the physician-patient relationship."

Mandates about the way physicians practice medicine will inevitably expose physicians to another area of potential liability, Dr. Freidheim added. "When appropriate medical care for patients differs from the insurer's guidelines, physicians must be even more diligent about documenting their actions. The impact of those stipulations on the legal standard of care has yet to be explored, but the outcome could be devastating to an already overwhelmed medical malpractice system."

ISMS HOUSE OF DELEGATES policy on practice parameters adopted in 1991 states that practice parameters may promote quality patient care when they are properly developed by physicians. However, the policy also urges "physician participation in continued evaluation to insure their proper use to promote improvement in patient care."

"Because this appears to be the first time an insurance company has tried to implement practice parameters, physicians are understandably worried about whether these guidelines will actually improve patient care," Dr. Freidheim said. "If properly drawn and applied, practice parameters can help ensure quality care and control costs. However, the Society wants assurance that BCBSI's actions do not place financial considerations above what's best for the people it insures.

"I strongly encourage ISMS members to consult their attorneys before signing an insurance contract with practice guideline provisions," Dr. Freidheim added.

For more information, physicians may contact the ISMS Health Care Finance Division at (312) 782-1654 or (800) 782-ISMS, ext. 1162. ■

IDPR DISCIPLINES

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

March 1993

Willard Eyer, Olney – physician and surgeon license placed on indefinite probation; controlled substance license indefinitely suspended after prescribing anoretic medications to some patients on a long-term basis.

Fe Poblete Funetes, Centreville – physician and surgeon license placed on indefinite probation after being disciplined in the State of Ohio.

Steven Hefty, Ohosen, IA – physician and surgeon license placed on probation for two years after being diagnosed as suffering from a bi-polar disorder.

Anna K. Knapp, North Lake – physician and surgeon license voluntarily surrendered after prescribing controlled substances for non-therapeutic purposes.

Lawrence Krain, Chicago – physician and surgeon license indefinitely suspended after failing to disclose a felony conviction from a sister state and for suffering from a mental illness.

Aaron Long, Valrico, FL – physician and surgeon license indefinitely suspended after being disciplined in the State of Florida, failing to pay Illinois Income Taxes for five years and for failing to pass the S.P.E.X. exam, which was a requisite of a previous Department order.

William J. Moffett, Chicago – physician and surgeon license placed on indefinite probation for a minimum of six months after failing to pay Illinois Department of Revenue taxes for four years and failed to file tax returns for three years.

Alexander Delos Reyes, Burr Ridge – physician and surgeon license placed on indefinite probation after being disciplined in the State of Michigan.

David Rowe, Fort Atkinson, WI – physician and surgeon license placed on indefinite probation after being disciplined in the State of Wisconsin.

Jayen Shah, St. Louis, MO – physician and surgeon license suspended indefinitely for filing a false report with the United States Air Force.

Charles Sutherland, Park Forest – physician and surgeon license placed on probation for seven years; controlled substance license indefinitely suspended after suffering from a substance abuse problem.

Pranan Vaidya, Oak Lawn – physician and surgeon license indefinitely suspended after violating a previous Department-ordered probation.

April 1993

Winit Dejsahrai, Morton Grove – physician and surgeon license placed on indefinite probation for a minimum of two years; controlled substance license indefinitely suspended after alleged gross negligence.

Young S. Koo, Hammond, IN – physician and surgeon license revoked after being disciplined in the State of Indiana.

Lawrence S. Krain, Chicago – physician and surgeon license, order signed in Circuit Court of Cook County, Illinois (93-CH03166) on 04/12/93 staying the Department's order dated 03/22/93 with the following conditions: Lawrence S. Krain, M.D., is not to engage in any act of medical practice or dermatology including medical consultation pending a final decision in the administrative proceedings.

David Massman, McHenry – physician and surgeon license placed on indefinite probation for a minimum of three years; controlled substance license indefinitely suspended after suffering from drug addiction.

May 1993

Fernando Cinta, Chicago – physician and surgeon license placed on probation for two years after allegedly prescribing a controlled substance for non-therapeutic purposes.

Harvey C. Kaplan, Chicago – physician and surgeon license revoked after violating a previous Department ordered probation.

James Vasilakis, Schaumburg – physician and surgeon license and controlled substance license placed on probation for three years for habitual use or abuse of Stadol.

June 1993

Michael J. Bolger, Chesterfield, MO – physician and surgeon license issued on probation for three years after answering affirmatively to a personal history question on his application for licensure.

Jerome Budz, Hoffman Estates – physician and surgeon license reprimanded for gross negligence.

Lee A. Crocker, Orlando, FL – physician and surgeon license placed on indefinite probation after being disciplined in the State of Florida.

Donald B. Garvin, Bay City, MI – physician and surgeon license revoked for a minimum of five years after being disciplined in the State of Michigan.

Robert C. A. Goff, Morris – physician and surgeon license placed on indefinite probation for a minimum of five years due to a criminal conviction.

Jan Eun Han, Elgin – physician and surgeon license reprimanded and fined $5,000 after failing to respond to a request for information from the Department and the Medical Disciplinary Board.

Seymour Schlager, Skokie – physician and surgeon license indefinitely suspended due to a criminal conviction.

Mark T. Stevens, San Diego, CA – physician and surgeon license revoked after violating a previous Department ordered probation.

July 1993

Toney Baskin, Florence, AL – physician and surgeon license indefinitely suspended after being disciplined in the States of Texas and Louisiana.

Lead ordinance

(Continued from page 1)

problem has been identified."

Under the ordinance, the city is authorized to levy fees on parents and building owners for required school lead screenings and building inspection services. That revenue would enable the Chicago Department of Health to increase inspections of high-risk buildings, Sister Sheila said. The department's lead program "has an enforcement system for lead abatement, which includes both compliance hearings and court action," she added.

The current law stipulates that when the city takes emergency measures to abate lead, it can recover the cost of abatement and tenant relocation from building owners, according to a fact sheet compiled by the Lead Elimination Action Drive, a citywide coalition of community organizations, health clinics and youth advocacy organizations. Violating the ordinance carries a maximum penalty of six months in jail and a $500 fine for each offense.

The ordinance also reiterates recent state legislation mandating lead screening for all children before they begin day care, preschool or kindergarten.

"We still see a big need for a larger lead program, but it's a good policy step forward," said John Knox, executive director of LEAD.

Knox said LEAD lobbied hard to include a provision stating that residential building owners must take responsibility for removing lead hazards from their buildings. "We looked at the early draft of the ordinance and said that if the object is to prevent instead of react to lead poisoning, we need some form of self-enforcement."

More than 1 million Chicago housing units were built before 1978, which puts them at risk for containing lead-based paint, said Sister Sheila. "Half were built before 1940. As our housing stock continues to age, it becomes more hazardous through peeling paint, and the health of our children is placed in jeopardy."

"It's estimated that one in five Chicago preschoolers has an elevated blood lead level," said Elizabeth Hawks, MD, a Chicago pediatrician and LEAD board member. Dr. Hawks said she believes children should not be used as indicators for high environmental lead levels. "Seventy percent of housing in Chicago has dangerous levels of lead. The only thing we can hope for is to get building owners to speed up abatement."

As part of its support for legislation regarding lead poisoning in children, ISMS House of Delegates policy endorses legislation establishing effective lead abatement programs. ■

Insurance companies

(Continued from page 1)

president of Cigna HealthCare, which insures 51,000 Chicago-area residents. "Although we agree with the broad goals of his plan, we do have some grave concerns about a number of the tools the president would use to achieve his goals," English said.

Purchasing cooperatives are intended to give individuals and small businesses access to reasonably priced health insurance, English said, but the president's proposal turns them into giant regulatory bodies. He said the administration's proposed health alliances would force 99 percent of all businesses and more than 80 percent of America's workers to buy their coverage from "bureaucrats who would have absolute authority over price, quality and the scope of health care. The size of these cooperatives will diminish competition, not increase it, and it will destroy the incentive private employers currently have to improve the health of their employees," English added.

Consumers should also be concerned about the ramifications of such a system, according to Blue Cross and Blue Shield of Illinois, an insurer for 2.5 million Illinoisans. "It appears to be a far-reaching and ever-growing bureaucracy that will deeply involve itself in our business, doctors' business and consumers' business," said Dennis Cullerton, a BCBSI spokesperson. "And it will be an expensive bureaucracy. When was the last time a government-run entity wasn't expensive?"

IF INSURANCE REFORMS such as community rating, portability and elimination of pre-existing conditions are enacted, the benefits of purchasing cooperatives could be achieved without the health alliances the president wants to mandate, Cullerton said.

Price controls proposed in the Clinton plan, like government-imposed caps on insurance and health plan premiums, also concern insurers, English said. "Price controls do not work. We know this from experience. You cannot hire enough bureaucrats and price-control police to effectively enforce the system."

"[Price controls] do not affect the most important aspects driving health care costs," said Alan Rosenberg, MD, medical director for Aetna Healthcare Programs' Midwest market, insuring 400,000 Illinoisans. "They create a large bureaucracy. It is not a feasible process, and it threatens quality and destroys incentives for innovation."

In addition, price controls will stifle competition, English added. "Doctors are joining networks or organizing themselves; hospitals are merging; new health plans are forming; and capital is pouring into the system – all of which has increased competition exponentially." He said the "invisible hand" of the market is moving reform ahead by transforming a health delivery system laden with inefficiencies into a more efficient system focused on quality and cost control.

BCBSI claims that several policies it has instituted during the last year will reduce costs and help prepare for the shift from traditional insurance coverage to managed care. Cullerton cited BCBSI's changes in its reimbursement schedule for specialists, which will provide more incentive for primary care doctors. And, in a move it says will increase quality of care while controlling costs, the insurer announced last month that it will institute practice guidelines for specialists participating in its new preferred network, an action vigorously opposed by Illinois physicians. (See story, page 1.)

"[At BCBSI], only 10 cents of every dollar goes toward administrative costs. I don't see how the government will top that," Cullerton said.

Although insurers would like for some aspects of the president's bill to be reexamined, overall, Aetna is pleased with its managed competition and managed care aspects, Dr. Rosenberg said. "It is very much in accordance with our own goals. We are working in cooperation with our physician base. Doctors are our partners. This is not an adversarial process." ■

Hospital networks

(Continued from page 1)

ships between physicians and hospitals are a logical mechanism to consider."

Dr. Kobler recommended that physicians organize formally to ensure they have a voice on important issues. Hospital medical staffs "ought to be on an equal level with the hospital governing board and the chief executive officer. Physicians should be careful not to relinquish rights and responsibilities, such as peer review." Other issues in which physicians should be involved include hospitals' financial operations, he said.

Hospital affiliations are the driving force behind reform, Scheer contended, noting that even without mandated changes in the system, the trend toward networking may be irreversible. In addition, hospital and network analysts seem to agree that hospital alignments will provide better services to patients at lower cost.

The following are some of the most recent Chicago-area hospital and network alignments:

• The member institutions of the Northwestern Healthcare Network voted to make the relationship official as of Nov. 2. Network partners are Northwestern Memorial Hospital, Children's Memorial Hospital, Highland Park Hospital and Evanston Hospital Corp., which includes Glenbrook Hospital. The Evanston board was the last partner to vote on the affiliation. Medical staff members had feared that Evanston Hospital could lose autonomy under the affiliation and that some of its services might be transferred to Northwestern.

• Last summer, Rush-Presbyterian-St. Luke's Medical Center became the third member of the Oak Park-based Synergon Health System. Synergon will continue to operate Oak Park Hospital and Westlake Health System, which includes Westlake Community Hospital in Melrose Park, but the institutions are also core components in the Rush network. The network includes Rush North Shore Medical Center in Skokie, Holy Family Hospital in Des Plaines, Copley Memorial Hospital in Aurora and Illinois Masonic Medical Center in Chicago.

For Rush, the affiliation means establishing comprehensive services for the 2 million patients served by the three hospitals, said Avery S. Miller, vice president of inter-institutional affairs and assistant to the president. "Our overall mission is to provide primary, secondary and tertiary care, while combining academic and managed care clinical programs."

The move will enhance access to primary health care services in the western suburbs, he said, adding that the network is also seeking hospitals in the far northern, southwestern and western suburbs.

• A recent merger between two out-of-state health care corporations has increased the new corporation's holdings in Chicago. Columbia Hospital Corp. merged Sept. 1 with Galen Health Care System (formerly Humana, Inc.), forming the Columbia Health Care Corp. This action brought Michael Reese Hospital and Medical Center and Hoffman Estates Medical Center under the Columbia umbrella. The corporation is currently negotiating the purchase of Grant Hospital, located in Chicago's Lincoln Park. The purchase should be final by January, according to Lori Fein, a Columbia spokesperson. By the end of the year, Columbia's board is also expected to vote on merging with HCA-Hospital Corp. of America, Fein said. If the deal goes through, three Chicago psychiatric hospitals would be added to the network.

Columbia entered the Chicago hospital market because many national companies are headquartered in the metropolitan area, said Gary Hill, Columbia's eastern division president. He confirmed reports that Columbia plans to add as many as 10 Chicago hospitals to its network over the next few years. "We're excited about Chicago. We want to be a major player in the delivery of high-quality, low-cost health care."

The Columbia/HCA Healthcare Corp. would own 190 hospitals in 26 states, including five in the Chicago area.

• Strengthening alliances among Catholic health care institutions, Columbus-Cabrini Medical Center announced Sept. 30 that Saint Anthony Hospital joined the Missionary Sisters of the Sacred Heart of Jesus, which owns and operates CCMC. The Franciscan Sisters Health Care Corp. transferred Saint Anthony to the CCMC network. The move marked the first time two Catholic religious congregations of women transferred sponsorship of a Chicago hospital.

CCMC now owns two West Side hospitals that have similar patient bases and share medical staff members, said Lee Domanico, CCMC chief executive officer. "Common ownership could lead to more comprehensive and cost-effective services," he said, adding that CCMC officials are "selectively looking for other hospitals" to add to the network.

• EHS Health Care and Ravenswood Health Care Corp. announced a new affiliation between EHS and Ravenswood Hospital Medical Center on the North Side of Chicago. Under the agreement made public Oct. 4, Ravenswood will become the first EHS hospital to retain significant local autonomy, according to EHS officials. Definitive terms of the affiliation will be negotiated over the next few months, but the Ravenswood board will maintain operational management of the hospital.

EHS owns and operates five Chicago-area hospitals. ■

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ERSE SERVICE-ORIENTED PROGRAMS (PAGE 7)

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • DECEMBER 17 1993

Happy holidays!



Your next issue of Illinois Medicine *will arrive by Jan. 14, 1994. Until then, we wish you a joyous holiday season and a happy new year.*



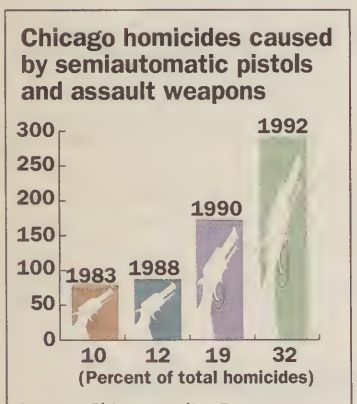
Physicians deliver the gift of medical care

PAGE 8

Cook County, CMS endorse gun control measures

INJURIES: Physicians say a county ordinance is a first step in curbing violence. By Anna Brown

[CHICAGO] As Congress haggled over the Brady bill last month, Cook County's new ban on assault weapons and ammunition went into effect. In addition, the Chicago Medical Society Council adopted a resolution calling for a ban on the "ownership, possession, purchase, sale, transport or transfer of handguns, semiautomatic and automatic weapons and their ammunition."



The Cook County ordinance mandated that residents possessing assault weapons turn them over to the sheriff, render them inoperable or remove them from the county by Dec. 1. Violating the ordinance carries a maximum six-month jail sentence and $1,000 fine.

"We've really got to stop violence," said John Barrett, MD, head of Cook County Hospital's trauma unit. Dr. Barrett said when he began working at the hospital in 1982, about 500 people were admitted to the trauma unit with bullet wounds. Ninety-five percent of those patients had been struck by single bullets from low-caliber handguns, he said. But in 1992, trauma unit physicians treated more than 1,000 patients for gunshot wounds, and 25 percent of the patients had more than one bullet wound inflicted by semiautomatic assault weapons, Dr. Barrett explained.

According to the Chicago Police Department, 70 people

(Continued on page 15)

INSIDE

Lung cancer in women up

PAGE 2

Pharmacy contract accord reached

PAGE 3



DEPARTMENTS

News Briefs.....2
Commentary.....4
ISMIE Update.....7
IDPR Disciplines..11
Classifieds.....13

Lawyer steals vaccine victims' compensation

THEFT: An attorney pleads guilty to defrauding his injured clients. By Gina Kimmey

[CHICAGO] Chicago attorney Anthony M. Colantoni pleaded guilty Nov. 22 to charges that he defrauded five physically disabled clients and their estates of $1.4 million under the National Vaccine Injury Compensation Program. Colantoni is scheduled for sentencing March 25 and faces a maximum sentence of 10 years in prison and a $500,000 fine.

"This is the first case of an attorney stealing his client's compensation under the VICP," said Michael T. Dyer, regional inspector general for the U.S. Department of Health and Human Services. Colantoni served as legal counsel on the second highest number of vaccine injury cases filed under the federal compensation program, Dyer said. This case has prompted the inspector general's office to look closely at other attorneys as well, he added. Currently, a "very limited number" of lawyers suspected of similar activities are under investigation, Dyer said, noting that none of those attorneys practice in Illinois.

Charges were filed against Colantoni in November, after HHS received complaints from parents of his clients claiming they had not received payment from the VICP. The clients were children who had experienced crippling injuries or died after receiving a childhood immunization. Colantoni accepted more than $1.5 million from the government for his clients between June 29, 1990, and Oct. 31, 1991, according to HHS. But

(Continued on page 12)

Tie one on for the holidays

MADD: During the holiday season, physicians and community leaders call attention to the problem of drunken driving. By Gina Kimmey



John McNulty

Ryan

[CHICAGO] At the Nov. 18 kick-off for Project Red Ribbon, members of Mothers Against Drunk Driving said increased drunken driving incidents are as much a part of the holiday season as shopping. To heighten awareness about drunken driving during the campaign, MADD is distributing red ribbons for drivers to display on their cars until Jan. 1, said Gary Kenzer, executive director of MADD Illinois.

"The number of people killed in impaired-driving crashes has dropped over the last 10 years, but even one death is too many," Kenzer said. "MADD is again asking motorists to tie one on for safety as part of Project Red Ribbon." Red ribbons on vehicles symbolize motorists' pledge to be sober when driving this holiday season and throughout the year and to remind others to do the same, he added.

Illinois Secretary of State George Ryan said 650 people were killed last year in Illinois in accidents involving drunken drivers. "We hope these ribbons, whether pinned to a coat or knotted around a car antenna, will provide a commonsense reminder that all [driving under the influence] deaths are preventable and that it's not OK to mix alcohol and automobiles."

Alcohol was involved in 18,000, or 46 percent, of all traffic fatalities nationwide in 1992, according to National Highway Traffic Safety Administration estimates. At EHS Christ Hospital and Medical Center in Chica-

(Continued on page 15)



M. Candee Studios

ISMS PRESIDENT Arthur R. Traugott, MD, presents physicians' goals for health system reform during a Dec. 1 meeting of the Illinois Senate Minority Leader's Task Force on Health Care Reform at Northwestern Memorial Hospital.

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Lung cancer in women up

[CHICAGO] The number of Illinois women diagnosed with lung cancer increased 58 percent in the last 15 years, according to new data released by the American Cancer Society's Illinois Division. Figures from the ACS's *Cancer in Illinois 1991: An Incidence Report by 111 Hospitals* show that of the state's lung cancer cases in 1991, 38 percent were diagnosed in women, up from 24 percent in 1976.

In addition, since 1987, more American women have been killed by lung cancer each year than by breast cancer, said Stephen F. Sener, MD, president of the ACS Illinois Division. "In 1993, 56,000 U.S. women will die of lung cancer. That's 22 percent more women than the 46,000 who will die of breast cancer," Dr. Sener said.

"The tragic fact is that lung cancer is killing more Illinois women than ever before in history," Dr. Sener continued. "This is directly attributable to cigarette smoking.

"Since World War II, when American women were urged to 'reach for a Lucky instead of a sweet,' females have been increasingly and deliberately targeted by the tobacco industry with marketing promotions, advertising campaigns and athletic sponsorships that link smoking to glamour, vigor and, most of all, a svelte figure," he added.

According to ACS, cigarette smoking is responsible for 79 percent of lung cancers in women and 87 percent of all lung cancer cases. In addition, Dr. Sener said women are not quitting smoking at the same rate as men. The number of men who smoke has dropped by 46 percent since 1965; the number of women smokers has decreased only 28 percent in that time.

ACS offers smoking cessation materials and programs for women, including free "quit kits" with tips on how to stop smoking, avoid weight gain and resist the temptation to smoke during the holidays. For more information, contact ACS at (800) ACS-2345. ■

Correction

The story "Lower DUI limits sought," published in the Dec. 3 issue of *Illinois Medicine,* states that a recent survey of Illinois voters was conducted by Kemper National Insurance Cos. The survey was actually commissioned by Kemper. ■

Lobbying law alters tax status of dues

Physicians should watch their mailboxes over the next few weeks for ISMS' notification regarding what percentage of their 1994 medical society dues will be tax deductible. Under a federal law that takes effect Jan. 1, the portion of professional society dues spent on lobbying expenses may not be deducted as an ordinary and necessary business expense. Also, the Internal Revenue Service issued guidelines stating that the law will apply to 1994 dues prepaid in 1993. ISMS urges physicians to consult their personal tax advisers regarding individual circumstances. ■



John McNulty

ISMS PRESIDENT-ELECT Alan M. Roman, MD, discusses physicians' views on health system reform during a Nov. 14 town hall meeting sponsored by state Rep. Carolyn Krause (R-Mt. Prospect). Dr. Roman was one of seven health care experts invited to speak at the forum. He explained physicians' concerns about maintaining quality patient care under reform.

CLIA proficiency testing deadline nears

[SPRINGFIELD] Time is running out for physicians who operate office-based laboratories to comply with federal proficiency testing regulations mandated by the Clinical Laboratory Improvement Amendments of 1988. As of Jan. 1, CLIA requires all physician office labs and testing facilities to conduct proficiency tests for the moderately and highly complex services they provide.

"We strongly recommend that facilities get signed up for their proficiency testing now if they haven't done so already," said Dick Waters, southern area supervisor for the Illinois Department of Public Health's laboratory regulation program. IDPH regulates office labs and conducts CLIA inspections for the U.S. Health Care Financing Administration, which oversees CLIA.

In April, IDPH inspectors began conducting biennial inspections of office-based labs that perform moderately and highly complex tests. The inspectors check for procedural manuals, quality control and quality assurance records, and documented personnel records. Labs receive two weeks' notice of a routine inspection.

After Jan. 1, inspectors will also look for evidence that labs are prepared to conduct proficiency tests, Waters said. Although physicians face sanctions for failing to enroll in a proficiency testing program, they will be given 90 days to comply, he added. "The problem at that point is that it may be hard for [facilities] to find a place to do their proficiency testing."

Labs still not in compliance after the 90-day grace period face possible HCFA sanctions including limitation or revocation of their CLIA registration certificate, cancellation of their Medicare or Medicaid approval, or suspension of their Medicare or Medicaid reimbursement. According to the *Federal Register*, monetary sanctions are penalties of last resort that would be imposed only if a lab is potentially harmful to the public.

Physicians who fail proficiency testing in 1994 will not be cited by IDPH unless the public's health is in danger. However, beginning Jan. 1, 1995, physicians who do not meet proficiency testing requirements will be sanctioned, according to ISMS advisers.

To obtain a list of government-approved proficiency testing services, physicians may call ISMS at (312) 782-1654 or (800) 782-ISMS, ext. 1211. ■

PHYSICIAN FACTS

How many drinks would someone have to consume in one hour to be considered driving under the influence of alcohol?

No. of drinks	% of respondents
One	14
Two	19
Three	23
Four	11
Five	3
Six	1
Don't know	29

Source: Office of the Secretary of State, statewide survey on DUI laws conducted for Kemper National Insurance Cos. in August 1993

EMF research introduced

[CHICAGO] Scientists presented the latest research about the effects of electric and magnetic fields on human health during a Nov. 10 forum in Chicago. The program, "Electric and Magnetic Fields: Science and Policy," was sponsored by Commonwealth Edison, Northwestern University and the University of Illinois at Chicago. Attendees included community leaders, elected officials and representatives from the medical and educational communities.

"We became aware that our customers had a number of questions about the impact of EMFs on health," said Samuel Skinner, president of Commonwealth Edison. "To this point, there had been no forum to answer those questions. We were fortunate enough to put together nationally known, leading experts in this field."

The program's goal was public education, and the sponsors sought a "good cross-section of public policy-makers and decision makers with an interest in the issue," Skinner explained. "Anyone who looks at the research comes to the conclusion that it's not a big health problem. But ignorance leads to uncertainty."

Despite the growing body of research, scientists have been unable to determine whether EMFs pose a threat to human health. Program speakers discussed current epidemiological studies on populations exposed to EMFs. "It's very difficult to draw a causal inference" between EMFs and negative health effects, said Robert S. Banks, a professional engineer, who is completing his dissertation in environmental health at the University of Minnesota School of Public Health. He is studying the effect of magnetic fields in homes. "There's a lot we don't know about EMFs and the effect they have on biological systems," he said. ■

Illinois physician dies

[CHICAGO] Oak Brook physician and ISMS member Ali A. Khalili, MD, 61, ended his three-year battle with bone cancer in a Michigan apartment last month. Dr. Khalili died Nov. 22 in Royal Oaks, Mich., in an apparent suicide assisted by Jack Kevorkian, MD.

Dr. Khalili had served as chairman of the rehabilitation department at Chicago's Grant Hospital until he retired in 1992 because of his illness. He was a graduate of Tehran University and was a diplomate of the American Board of Physical Medicine and Rehabilitation since 1964. He joined Grant Hospital's medical staff in 1968 and was a founding member of the rehabilitation department, becoming department chairman in 1977. Dr. Khalili was also affiliated with the Rehabilitation Institute of Chicago and Northwestern University. ■

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Pharmacy contract accord reached

MAIL-ORDER DRUGS: A disagreement over how to provide state employees with a drug benefit ends amicably. By Anna Brown

[SPRINGFIELD] The Illinois Department of Central Management Services reached an agreement with the Illinois Pharmacists Association on a package to provide state employees with prescription drugs. Gov. Jim Edgar announced Oct. 8 that the state would continue using a network of community pharmacists – instead of a mail-order drug firm – to provide drugs for the State Employees Group Health Insurance program at a substantial savings.

Patients sometimes run out of medications they take regularly. In these cases, there is no time to wait for the mail delivery, so patients will go to the local pharmacy.

A dispute arose between the two groups when the state entered into a tentative agreement with a mail-order pharmacy in 1991 to start a pilot program for retired state employees, said Mark Schmidt, a CMS spokesperson. The new agreement will result in annual savings of $2.5 million, an amount comparable to what would have been achieved by contracting with the mail-order firm, Schmidt said.

"This package will save taxpayers and state employees substantial sums of money without taking business away from pharmacists," Edgar said. "It negates the need for us to move ahead on a controversial contract with a mail-order drug firm."

"This settlement is a tremendously positive situation for the state, the employees and their union," said IPhA President Gary Reynolds. "The employees, retirees and their dependents will all benefit from lower out-of-pocket expenses while receiving high-quality pharmaceutical care. And the state and taxpayers benefit from lower costs to provide the benefit to its employees."

Some of the measures CMS and the pharmacists negotiated under the agreement include increased discounts for state employees and an overall reduction in dispensing fees. In addition, the agreement provides incentives such as higher reimbursement for pharmacists to substitute generic drugs and fill maintenance prescriptions for longer periods of time, CMS officials said.

The ISMS House of Delegates adopted policy in 1991 to seek information from its members concerning inappropriate practices by mail-order pharmacies. The policy also states that if necessary, the Society will seek legislation or regulatory solutions to quality-of-care problems caused by the practices of mail-order pharmacies.

IPHA ORIGINALLY OBJECTED to the program because it provided a financial disincentive for retirees to use community-based pharmacies, according to IPhA officials. Also, the pilot program could have caused patients to use the mail-order pharmacy in medically inappropriate situations.

"Mail-order pharmacies are becoming very popular," said Joseph B. Perez, MD, chairman of the ISMS Drugs and Therapeutics Committee. The inconvenience of mail-order firms is that many require that maintenance prescriptions be filled at three-month intervals, he explained. "If the medication needs to be changed during this period, the rest must be thrown out. It's a waste."

"There are companies trying to convince patients to use their services inappropriately," said Jim Flanigan, an IPhA spokesperson. There is often a lag time in processing mail-order purchases that doesn't exist in community pharmacies, and patients may require counseling from pharmacists about certain medications, he said.

Patients sometimes run out of medications they take regularly, Dr. Perez said. In these cases, there is no time to wait for the mail delivery, so patients will go to the local pharmacy, he noted. ■

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REPORT FOR *Illinois Physicians*

"PRACTICE GUIDELINES"

Practice Guidelines, which are, in effect, recommended diagnostic and treatment approaches for specific clinical conditions or episodes of care, are a well established part of American medical practice. A number of highly respected and prestigious medical organizations and agencies, only two examples of which are the American Medical Association and the American College of Physicians, have been actively involved in the development and promulgation of practice guidelines. Therefore, practice guidelines are not radical departures, but rather are mainstream medical developments.

Recently, Blue Cross Blue Shield of Illinois (BCBSI) announced that beginning in 1994, certain types of specialists in one of BCBSI's managed care products (Managed Care Network Preferred, a so called "point-of-service" type product) will be asked to sign a contract which includes a provision that the specialist "agrees to practice in accordance with clinical guidelines as set forth by BCBSI". These guidelines have not been developed by BCBSI, but rather have been proposed by professional specialty societies, consensus panels, and health care agencies, and reflect the recommendations of current peer-reviewed medical literature. The guidelines that have been put forth by BCBSI thus far pertain to the specialties of cardiology/cardiovascular surgery, oncology, and general surgery; guidelines related to certain orthopedic surgical procedures will follow soon. Furthermore, it is the intent of BCBSI to have existing guidelines reviewed and possibly revised at least annually by outstanding specialists in the applicable specialties, to make sure that the guidelines are consistent with the latest advances in medical knowledge and practice, and to add new guidelines in the same or other specialties each year; the new guidelines will have the same professional backing and validation as the previous guidelines.

BCBSI realizes that the inclusion of a provision in the specialists' contracts that they will practice in accordance with certain guidelines, is a new departure, since to BCBSI's knowledge, it is the first insurance carrier or managed care company to do so. However, it is BCBSI's commitment to review only in general the overall compliance of a physician with the guidelines; deviation in an individual case will be accepted. Of course, claims will be paid according to the patient's health care contract, even if the services provided were not consistent with the guidelines.

Critics of practice guidelines contend that they will lead to "cook-book" medicine. However, the clinical guidelines put forth by BCBSI are clinical policy statements. The guidelines are not detailed practice algorithms; consequently, there is much room for physician decision-making in the application of the guidelines. Furthermore, no practice guideline addresses the art of medicine, i.e., the role of the physician as the intelligent and compassionate provider and director of total health care.

Practice Guidelines have been endorsed by BCBSI as a quality management methodology whereby BCBSI's enrollees might have more uniformity in the provision of high quality health care services. Although guidelines will probably result in increased efficiency of services, the primary thrust has been quality improvement. Finally, the ability of a physician to demonstrate that he/she has complied with guidelines developed by clinical leaders, should help the physician mount a more effective defense in possible malpractice litigation. BCBSI truly believes practice guidelines to be in the best interest of both physicians and their patients.

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EDITORIAL

Physician involvement not negotiable

Blue Cross and Blue Shield of Illinois' new mandated practice guidelines could have long-range harmful effects on the extent and kind of care Illinois physicians give their patients.

BCBSI *unilaterally* imposed these guidelines without the knowledge and consultation of ISMS and, most likely, the 1,300 physicians participating in its Managed Care Network Preferred program. The guidelines cover four specialties and 14 medical procedures, and are scheduled to take effect Jan. 1.

ISMS encourages all physicians to seriously consider the liability consequences that may stem from entering into a contract that includes the BCBSI guidelines. If physicians' professional judgment is replaced by nonphysician-created guidelines, these mandates will inevitably expose physicians to another area of potential liability. When appropriate medical care for patients differs from the insurer's guidelines, physicians must be even more diligent about documenting their actions and always acting in patients' best interests. The impact of these guidelines on the legal standard of care has yet to be explored, but the outcome could be devastating to an already overwhelmed medical malpractice system.

ISMS has no objection to practice parameters developed and approved by practicing physicians and applied appropriately to individual patient circumstances. But BCBSI has adopted one set of guidelines and demanded that they be followed. What happens if other insurers develop their own guidelines? When an insurer tells a doctor how to practice the art and science of medicine, the overall effect may be that the patient suffers at the expense of the bottom line.

ISMS is greatly concerned about unilateral insurance company edicts defining medical practice in Illinois. BCBSI calls this "real health care reform for patients." In reality, these clinical dictates could constitute new and potentially harmful standards of patient care.

The new BCBSI-mandated guidelines are the subject of a paid advertisement on page 3 of this issue. We urge all ISMS members to read this advertisement and carefully consider what BCBSI says it intends to do. Before signing any contract that includes mandated practice guidelines, you may wish to consult your personal attorney.

ISMS has taken steps to obtain and review the guidelines, as well as to learn more about their development, substance and application by the company. ISMS will take whatever action is necessary and appropriate to ensure that these guidelines do not hinder patient care and do not increase patients' health care costs because of the impact on Illinois' medical malpractice climate.

ISMS' overriding concern is that following these guidelines may take precedence over individual patients' needs.

PRESIDENT'S LETTER

'Reforms' must benefit our patients

By Arthur R. Traugott, MD



Our bottom line is that practice guidelines must never place financial considerations above what's best for our patients.

Last month, Blue Cross and Blue Shield of Illinois announced it would impose practice guidelines on about 1,300 physicians who participate in its new specialty referral network. The guidelines were established in four areas – cardiology, oncology and general and orthopedic surgery – and apply to 14 medical procedures. Since the announcement, Illinois physicians have expressed serious concerns about those guidelines and their potential harm to patient care. Acting on those concerns, ISMS has succeeded in drawing media attention to the issue and has notified physicians statewide about the problem.

We cannot assume that every "reform" proposed as part of health system reform will benefit our patients. ISMS advocates medical cost-effectiveness and practice parameters developed directly from clinical practice. However, we believe that physicians and patients must be equal partners with insurers in reforming the system. Insurance companies do not provide direct medical care, so they are simply not qualified to act alone. We are deeply troubled that an insurer might let its financial agenda dictate how physicians treat their patients. ISMS believes that patients' needs must always come first.

The foundation of the physician-patient relationship is patients' confidence that their doctor is using his or her best judgment for their particular situation. It is possible to develop practice guidelines that do not undermine the physician-patient relationship, but those guidelines must be developed by physicians according to local standards of care, and the primary criterion must be maintaining high-quality patient care, not a company's bottom line. Guidelines must also allow physicians to use their clinical judgment to do what's best for their patients – even if that means deviating from the guidelines.

We have learned about some aspects of the BCBSI guidelines, but we still have many unanswered questions and concerns. In developing the guidelines, BCBSI did not seek broad-based input from organized medicine. In addition, the guidelines may open the door to an insurance company-dictated standard of care, which may worsen the medical malpractice climate in Illinois. It is also unclear how much leeway physicians will have when clinical circumstances warrant deviating from the guidelines and how much liability physicians might incur if the guidelines restrict their clinical judgment. We do know that physicians who repeatedly deviate from the guidelines without cause will be asked to leave the network.

Then there's the question of evaluation. How will the guidelines be monitored and updated, and by whom? ISMS House of Delegates policy urges "physician participation in continued evaluation to insure their proper use to promote improvement in patient care."

ISMS is also concerned about the precedent set by BCBSI. Will every insurer now develop guidelines using different sources, methodology and implementation strategies? If so, the potential exists for extreme variations in patient care.

Perhaps the most relevant example of insurance companies and their approach to patient care is utilization review. At times, companies may pressure physicians to base their approach to care on cost considerations, not the needs of individual patients.

On behalf of our 18,000 members, the ISMS Board of Trustees has appointed a physician delegation to meet with BCBSI to learn more about the guidelines. The board will also take appropriate actions to ensure that these guidelines do not harm patient care or increase patients' health care costs by exacerbating the medical malpractice situation.

ISMS is concerned that BCBSI's action may indicate that its primary aim under health care reform is strengthening its bottom line. Our bottom line is that practice guidelines must never place financial considerations above what's best for our patients.



"According to the tests, you're allergic to reindeer."

GUEST EDITORIAL

Surviving the hard road ahead

By Martin A. Murcek, MD

This article was originally published in the November 1993 issue of Pennsylvania Medicine. *It is reprinted with permission.*

Are you worn down by all the negative press directed at the "medical establishment" these days? If you believe the paper or TV news, you could get the impression that most Americans would rather be seen by Hillary Rodham Clinton next time they're sick, rather than by a qualified physician. Let me point out some things that should cheer you up.

First, having been summarily excluded from the "Health Care Reform Task Force," doctors won't be due any blame for anything that gets "reformed" into an even bigger mess. This fact alone will, I believe, be a big source of comfort to doctors everywhere as "health system reform" emerges as more boondoggle than boon.

(I hope you have warmed to the fact that these thoughts are tongue-in-cheek in nature.)

Also, the "reform" issue has displaced a whole raft of gloom-and-doom issues that get too much play in our journals: Doctors are going to be slaves to hospital administrators; we're going to be sued out of business; crooks are going to get all our retirement money; young, new doctors are going to push us out of our jobs before we're ready. All of these dire predictions have a silver lining. Let me illustrate.

"Reform" is going to put hospital administrators in the same boat as private practitioners, struggling against arbitrary, inane regulations and spending too much time on useless paperwork. It's our boat, though; we don't have to let them on board. Nobody ever said misery isn't choosy about the company it loves.

As for being sued out of business, reports that 50,000 new bureaucrats will be needed to run the government's "health alliances" suggest that some attorneys will be distracted by the prospect of all those juicy do-nothing jobs, giving us a breather. There's even more to look forward to down the road, when some of those attorneys come in search of treatment for ulcers, migraines and other job-stress-related problems.

I think reform will also get crooked financial advisers off our backs. Those shrewd operators will be the first to figure out where the billions in government health care funds are actually going, and they will follow. The media says the money won't be coming our way, so the scam artists won't be coming our way either.

I could probably go even further in this tongue-in-cheek manner, but the point is, all of the issues discussed above are serious. My goal isn't to belittle the issues or the aggravation and anguish they have caused for honest, hard-working doctors in America today, but to remind you that you can't do your job well if you become obsessed with the problems associated with the job. As some wag once noted, "If it was fun all the time, it wouldn't be a job, and you wouldn't get paid for doing it!"

Even with all the headaches and drawbacks, 27 years of practice have only increased my conviction that no job offers the excitement, challenges, rewards and gratification of medical practice. Like many of you, I have learned more than I care to know about the construction business, agriculture, retail sales, the used-car business, real estate and, yes, even politics, in the course of commiserating with my patients during their visits.

One of the foundational tenets of organizational behavior is continually reinforced by these convictions: Everyone thinks that his or her job is the hardest of all and that he or she is the least equitably compensated for all that hard work.

So, don't let the others wear you down. We have a hard road ahead, coping with change for the sake of change, along with the other problems described above. To colleagues of my vintage, I say, don't treat the young doctors as competitors, treat them as colleagues. You were a young doctor once yourself, after all.

And finally, when the American people get fed up with all the ill-advised meddling in their health care choices, we'll be having much more fun than some politicians and bureaucrats!

Dr. Murcek is president of the Pennsylvania Medical Society.

GUEST EDITORIAL

The Republican approach to affordable health care

By U.S. Rep. J. Dennis Hastert

The following editorial originally appeared in the November-December 1993 issue of Rising Tide, *published by the Republican National Committee. It is reprinted here with permission.*

All Americans welcome the challenge to action on health care reform. We need change, but we must be sure that change preserves the excellence of our health care system as it seeks to correct its weaknesses.

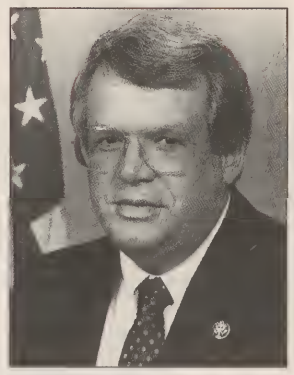
It is hard to discuss health care reform briefly, but three broad concerns stand out. We must eliminate discrimination against some Americans by the insurance industry, control costs and improve access so that each American can purchase a health insurance policy that he or she can afford.

House Republicans agree with President Clinton that we cannot allow insurance companies to pick and choose whom they will and will not insure or to discriminate against high-risk families. It is simply wrong. And in our plan, like the president's, we make it illegal.

Our Republican approach to cost containment and improving access, however, differs from the president's. The president believes that the government should define your health insurance benefits and tell you where to buy insurance. He then requires you and your employer to pay for it. The president's plan also establishes a huge government bureaucracy to run the system and attempt to control prices. Experience shows us that government mandates limit choice and often cost jobs in small businesses. As for government price controls, when have they ever worked?

Republicans believe Americans want a choice of competitive health plans. They also believe most Americans want to provide insurance for themselves and their families and that they will do so if they can get a fair price and a helping hand through tax deductions, like large businesses do. We accomplish these objectives in our new bill, the Affordable Health Care Now Act of 1993, and we do it without limiting choices or undermining the highest quality of care in the world.

How do we contain health care costs? The Affordable Health Care Now Act of 1993 targets the key cost drivers by reforming the malpractice system to limit frivolous lawsuits and reduce the costs of defensive medicine. The plan also reforms antitrust laws so that each hospital would not have to buy the latest, and often very expensive, piece of diagnostic equipment.



Rep. Hastert *(R-Batavia) is a member of the House minority task force on health care reform and served as the Republican representative to the White House health care task force. He serves on the House Energy and Commerce Committee, which has jurisdiction over health reform legislation.*

The House Republican plan also reduces paperwork and encourages the development of electronic billing. It closes loopholes to eliminate the billions of dollars lost in medical fraud and abuse. Finally, the House Republican health care reform plan will give Americans the ability to set up "Medisave" accounts, in effect medical Individual Retirement Accounts, to pay for routine medical expenses. The Medisave concept puts the consumer, not distant federal bureaucrats, in charge of deciding which treatments are necessary and cost-effective.

How do we make health care available to all Americans? The House Republican plan increases access in several ways. Under the plan, small businesses and their employees are empowered to group together so that they can enjoy the same advantages of what Mrs. Clinton calls "bulk purchasing," an advantage that is currently reserved for larger firms. The plan eliminates Internal Revenue Service regulatory barriers that prevent employer groups from being able to offer health insurance. For example, the American Farm Bureau or National Federation of Independent Business could offer group insurance to all of its members nationwide.

The House Republican plan also expands the tax deductibility of health insurance to the self-employed and uninsured individuals, giving them the same helping hand government now gives to large business. Our plan gives the states the flexibility to reform their Medicaid programs so that they can expand access to health care for low-income families.

And as for long-term care for the elderly? Americans would be able to deduct the cost of long-term care insurance or use their Medisave accounts, IRAs or life insurance, tax-free, to pay for it.

These reforms have broad, bipartisan support and could be enacted now. We will be able to feel their positive effects immediately. They preserve choice, and they don't create a government system with its complicated, unworkable bureaucracies. They are a prescription for real change.

Illinois Medicine *is looking for physician-written guest editorials on health care issues. If you have an idea you think might interest your colleagues, contact* Illinois Medicine *at (312) 782-1654, ext. 1261, or (800) 782-ISMS.*

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ISMIE Update

Insurance company-mandated practice guidelines may expose physicians to potential liability

PAGE 4

Lobbying law alters tax status of dues

PAGE 2

ISMIE offers diverse service-oriented programs

From clinic coverage to trial reimbursement, a wide range of Exchange services benefit policyholders. By Anna Brown

Physicians seeking exceptional service in addition to comprehensive liability protection should review the variety of programs ISMIE offers, said Harold L. Jensen, MD, chairman of the ISMIE board of governors. Since the Exchange is physician-owned, policyholders can expect physician involvement at every level – from underwriting to physician review. But some physicians may not be familiar with the programs the company has designed for convenience and premium savings, Dr. Jensen said.

"ISMIE policyholders can always expect the highest level of service in defending claims, offering protection options, delivering risk management expertise or responding to questions and concerns," he added.

Among the services and programs that are unfamiliar to some insureds are the ISMIE clinic option, the defendant reimbursement program, physician review and the Exchange's toll-free telephone number, according to an extensive policyholder survey conducted last summer by the Coldwater Corp. of Ann Arbor, Mich. In addition, some physicians are unaware of the variety of coverage options available, the survey found.

> *Through positive risk prevention, clinic option policyholders can earn total premium savings of up to 28 percent.*

"The Exchange is dedicated to providing secure, comprehensive medical malpractice insurance," Dr. Jensen said. "In our company, quality service applies to all programs. However, physicians can't take advantage of these opportunities if they don't know they exist. For instance, the ISMIE clinic option offers policyholders substantial savings on premiums."

Groups of five or more physicians are eligible for the clinic option, said Alfred J. Clementi, MD, chairman of the Illinois State Medical Insurance Services board of directors. Once a physician group selects the clinic option, ISMIE completes an evaluation that could result in scheduled premium rating credits of as much as 15 percent. "After clinic groups have been insured with ISMIE for at least one policy year, they may gain additional experience credits of up to 13 percent," Dr. Clementi said. "Through positive risk prevention, clinic option policyholders can earn total premium savings of up to 28 percent."



Whom should I examine first, you or your lawyer?

Physicians also have a number of other coverage options available to them, Dr. Clementi said. These include prior-acts coverage, suspended coverage and coverage for nonphysician employees.

PROMOTING ACTIVE physician involvement in defending claims has proved highly successful for the Exchange, Dr. Jensen said, noting that the ISMIE defendant reimbursement coverage program helps facilitate that participation. Under the program, physicians are compensated $500 per day, up to a total of $5,000, while attending trials or observing depositions other than their own. "Physician participation in building a solid defense has helped ISMIE to close more than 80 percent of its claims without indemnity payments," he said.

"Physician ownership also affects the Exchange's claim review and underwriting processes," Dr. Clementi explained. The members of the ISMIE Underwriting Committee, Physician Review and Evaluation Panel (PREP) and Physician Review Committee (PRC)

(Continued on page 12)

MALPRACTICE ROUNDUP

Risks of combined surgeries

A recent Texas case reviewed the risks of performing two surgical procedures simultaneously. According to the *Malpractice Reporter*, a physician initially refused to perform an abdominoplasty and liposuction until the patient lost weight. But by the time the patient had done so, she had developed cholelithiasis, and another surgeon had scheduled her for a cholecystectomy. The patient requested that both procedures be performed at the same time, and the physicians agreed.

Prior to the surgeries, the patient signed informed-consent papers regarding the risks of each surgery. In addition, a postoperative report stated that the patient was informed that undergoing concurrent abdominal surgeries slightly increases the risk factors. The procedures were performed uneventfully in less than four hours – the time that just the abdominoplasty and liposuction would usually take.

Following surgery, the patient developed skin necrosis and claimed she needed more medical care and surgery to correct the scarring, which she alleged caused her mental anguish. She filed suit against both physicians, maintaining she was not informed of the increased risks associated with performing the surgeries simultaneously. However, because there were no complications during surgery, the physicians' evidence negated the plaintiff's claim that combining the surgeries caused her injuries. Under Texas law, the burden of proof then shifted to the plaintiff, who could not present expert medical testimony to support her claim. Summary judgment for the physicians was confirmed on appeal. ■

AMA testifies on liability reform

AMA President Joseph T. Painter, MD, told two congressional panels Nov. 10 that President Clinton's health system reform bill does not adequately address medical liability issues. According to *AMA This Week*, Dr. Painter said the Clinton bill fails to impose caps on pain-and-suffering awards, which are the "single most important factor in containing medical liability costs." Like ISMS, the AMA supports a $250,000 cap on noneconomic damages. Dr. Painter also said the bill's one-third cap on contingency fees is "virtually no limit at all," since that is already the norm in most liability cases and is the law in Illinois.

While addressing the panels, Dr. Painter said the AMA proposes using the liability model adopted in California and Indiana, where premium costs have been successfully lowered. The AMA also spoke against enterprise liability, saying it does not represent "any improvement over the present system." ■

MEDICINE ABROAD

Physicians deliver the gift of

Disadvantaged people all over the world benefit from Illinois doctors' goodwill.

BY JANICE ROSENBERG

For a number of Illinois physicians, working visits to Third World countries have been enlightening and rewarding. Bringing their own endoscopes and X-ray equipment, they offer expertise to local practitioners who toil without antibiotics and discover what life is like for patients who have never received even minimal preventive health care.

– SIBERIA –

Fighting heart disease in Siberia was the focus of an educational effort undertaken in October by Zev Davis, MD, and 10 other health care professionals from Edward Hospital and Edward Cardiovascular Institute in Naperville. The team spent nearly two weeks at the Interregional Center for Cardiovascular Surgery in Krasnoyarsk, Siberia, an isolated Russian city with about 1 million residents.

Cardiovascular disease is the leading cause of death in Russia, but less than 10,000 patients have access to surgical treatments for the disease, according to Edward Hospital officials. Meanwhile in the United States, where cardiovascular disease is also the No. 1 cause of death, more than 650,000 patients undergo open-heart surgery each year, officials said. To help alleviate this disparity, Dr. Edward Svetlichny, director of the center in Krasnoyarsk, suggested the educational exchange to Dr. Davis in 1992.

As a preliminary step, Dr. Davis and cardiologist Vincent J. Bufalino, MD, visited the center last year to assess its needs. Although 750 of the center's 1,000 beds are used for cardiac patients, the facility lacked a cardiac catheterization laboratory. "If someone came in with a heart attack, he'd be put to bed for three to six weeks and be given a few medications – if they had them," Dr. Davis said of the center's limited resources.

Dr. Davis told Dr. Svetlichny that for the Edward team to conduct any meaningful teaching during its stay, a catheterization lab was essential. After a year of intense planning and coordination, the necessary equipment was gathered and shipped to Krasnoyarsk, and the American team left for Siberia. In addition to building the catheterization lab, the team also assembled a surgical suite and an intensive care unit.

Once the equipment was in place, the physicians began teaching. They demonstrated open-heart surgical techniques and lectured on the role of preventive education, noninvasive diagnostics, postoperative care and case administration. "Every procedure was observed by a minimum of 50 people," said Dr. Bufalino. "With people viewing from within the surgical suite, as well as through a plate glass window, we felt pressure to perform. The pressure and body heat, combined with no air conditioning, resulted in temperatures above 100 degrees during many surgeries."

We felt pressure to perform. The pressure and body heat, combined with no air conditioning, resulted in temperatures above 100 degrees during many surgeries.

Krasnoyarsk physicians are now able to perform cardiac catheterizations on their own. And two of the hospital's younger surgeons were selected to spend time in Moscow or Kiev learning the basics of coronary and cardiopulmonary bypass. The physicians may also come to the United States for further training at Edward.

"This was an opportunity to impact on a community with a great need, for no other reason than to be able to share knowledge," Dr. Davis said. "We're very fortunate in this country. It was nice to be able to share some of that."

MEDICINE ABROAD

ledical care



Rosanne Percivalle

– LITHUANIA –

After treating Lithuanian children at Chicago's Shriners Hospital for Crippled Children for three years, John P. Lubicky, MD, agreed to head a medical team to treat children in Vilnius, Lithuania. In October, the physicians spent an intensive week of performing orthopedic surgery and educating health care workers at the University of Vilnius Orthopedic Children's Hospital. Lithuanian Children's Hope, a Chicago charity, helped organize the endeavor.

To lay the groundwork for the trip, Dr. Lubicky spent five days in Vilnius in January 1993 surveying the facilities, meeting doctors and examining and screening 160 children. "The problem was, they had no instrumentation," he said. "It took us eight or nine months [after the first visit] to collect donations of equipment from companies, hospitals that were clearing their inventories and private people, and to get our team together."

Overall, the team delivered about $800,000-worth of medical equipment, including implants, spinal rods, gloves, gowns and antibiotics. During their stay, the physicians performed about 36 operations.

In Vilnius, where rounds start at 8 a.m. and surgery usually begins at 10 a.m., Dr. Lubicky's team was in the operating room by 7:30 a.m. "I designed our visit to stress their system and see what they could do," he said. "It worked pretty well, but they didn't like it." Dr. Lubicky attributes the lax attitude of Lithuanian health care personnel to Communism. "When the Communists were in control, people had their jobs subsidized. Now they don't have that, and they don't understand the free market. We hope we made more of a contribution than just doing a bunch of surgeries. Our idea was to give them a little push and show them our work ethic."

– COLOMBIA –

A group of Chicago physicians with a long-standing connection to the University of Cartagena in Colombia spent a week teaching and seeing patients in that country in October. Everildes Yarzagaray, MD, a pul-

(Continued on page 10)

Medicine abroad

(Continued from page 9)

monologist at Chicago's Norwegian American Hospital, led the trip in collaboration with Cartamedas, a Chicago association of Colombian physicians. The group works to deliver updated medical specialty knowledge to the University of Cartagena and for the past 12 years has sponsored a biennial medical conference in Cartagena featuring different subspecialties.

According to Dr. Yarzagaray, who travels to Colombia several times each year, the group's newest project is building a hospital in the small town of Arjona. "The existing facility is just a small clinic, and it doesn't provide the care needed. When we go there, we run community programs covering topics like breast cancer and AIDS. Meeting with people in the town is most rewarding."

The physician group also provides medical instruments and supplies to the university and clinics in a number of small towns, she said. Dr. Yarzagaray said one of her favorite programs is the hydrocephalic valve bank. On their most recent trip, group members took 25 valves donated by the Cartamedas auxiliary and Dr. Yarzagaray's husband, Luis, a neurosurgeon, to treat hydrocephalic patients.

— UZBEKISTAN —

To help bring modern health care to the Third World, David J. Sales, MD, and Stanley M. Zydlo Jr., MD, participated in the Second Universal Health Conference and Exhibition in September in the Republic of Uzbekistan's capital city, Samarkand. Attendees represented more than 35 countries.

At a micro-hospital set up for the conference, physicians from developing nations observed procedures and technology used in the United States, Germany, France and Great Britain. Dr. Sales, chief of gastroenterology at Northwest Community Hospital in Arlington Heights, performed 33 endoscopic examinations. "Because they don't have medicine there, diseases tend to go to their full conclusions," he said. "I saw end-stage disease, people with blockages of their stomachs or bleeding."

Dr. Zydlo, chief of emergency medical services at Northwest Community, demonstrated several procedures during the conference. "They have no labs. The people do the best they can, but they aren't excited about the urgency of things. Their attitude is, you have this [medical problem], and if you die, you die."

Both doctors called conditions in the city's hospital bleak. Rooms are starkly furnished, barely holding five cots and five chairs. Patients' families must bring them food and find sources for the medicines physicians prescribe. Needles, tubing and IV bottles are boiled and reused, leading to a growing rate of AIDS, especially in children. "In surgery, they're wearing cotton masks that don't stop anything, with their noses sticking out above," noted Dr. Zydlo.

By using foreign aid, Uzbekistan was able to purchase all the equipment brought to the conference. "The people are doing much better now that they're out of the Soviet Union," Dr. Sales said.

— UGANDA, ETHIOPIA —

Tropical medicine has always been the first love of Maryalice Vanderkooi, MD. In 1989, she journeyed to Uganda to work in a clinic established on the front porch of a church by Irish doctor Ian Clarke. Dr. Vanderkooi spent a month there, taking over for Dr. Clarke while he went home to raise money for the clinic. "Before Dr. Clarke arrived, there was no medical care system," said Dr. Vanderkooi, who holds a diploma in tropical medicine and hygiene from the Bangkok School of Tropical Medicine in Thailand. "They had a 90-percent mortality rate among African children who had measles."

She went back to Uganda in 1990 and relieved Dr. Clarke for two-and-a-half months. By then he was working in a newly built, thriving hospital. Since her return to the United States, Dr. Vanderkooi has been working in Freeport Memorial Hospital's emergency room. But next summer she will fulfill her dream of working in the Third World. She plans to establish a clinic in Ethiopia's Harrarge province, in the eastern part of the country, not far from the Somali border.

Dr. Vanderkooi said she chose Ethiopia because of its need for physicians. "What makes it so interesting is that most of the problems you see in developing areas are infectious diseases that have been wiped out [in the United States]. With just a few bottles of antibiotics, you have such fantastic technology relative to the problem."

On Dec. 8, Dr. Vanderkooi and her husband left for Ethiopia to conduct a "survey trip." She has no funding for the clinic yet, but she is optimistic about her move. "It's what I've wanted to do for a long time." ■

Holiday hours

ISMS and ISMIE offices will close for the holidays at noon on Dec. 23 and reopen at 8:30 a.m. on Dec. 27. The offices will also be closed on New Year's Eve, Dec. 31.



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IDPR DISCIPLINES

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March 1993

The following persons' physician and surgeon licenses were placed in a refuse to renew status after defaulting on their Illinois Student Assistance Loans:

Anthony Alexander, Chicago
William R. Almon, Palatine
Anita M. Beck, Broadview
April L. DeWhite, Chicago
Byron C. Glenn, Carbondale
Suzanne Lafollette, Barrington
Richard A. Mazur, Arlington Hts.
Linda R. Murray, Chicago
Hythem P. Shadid, Oak Park
Lynn Terese Shepler, Chicago
Anthony Zalduendo, Chicago

July 1993

Peter Dragisic, Chicago – temporary medical license issued on indefinite probation due to a substance abuse problem.

Patricia Gale, Chicago – temporary medical license issued on indefinite probation after answering affirmatively to a personal history question on her application for licensure.

James C. Hanley, Burlington – physician and surgeon license revoked after being disciplined in the State of Wisconsin.

Charles Henry Herbstman, South Pasadena, CA – temporary medical license issued on indefinite probation for a minimum of 3 years due to a substance abuse problem.

Daniel L. Icenogle, Madison, WI – physician and surgeon license reprimanded after being disciplined in the State of Wisconsin.

Michaelis B. Jackson, Carbondale – physician and surgeon license reprimanded after being convicted of mail fraud in the United States District Court.

Jitendra Kumar Mohindra, Jersey City, NJ – temporary medical license issued on indefinite probation after allegedly having an unsatisfactory performance evaluation in a postgraduate clinical training program.

Yongam Park, Hawthorn Woods – physician and surgeon license revoked for a minimum of five years due to multiple violations of the Illinois Medical Practice Act.

James H. Seubold, Streator – physician and surgeon license placed on indefinite probation for a minimum of three years; controlled substance license indefinitely suspended for a minimum of three years due to alleged multiple violations of the Illinois Medical Practice Act.

Robert Sindel, Belleville – physician and surgeon license placed on probation for three years due to alleged dishonorable, unethical and unprofessional conduct.

August 1993

Harold Bizer, East St. Louis – physician and surgeon license revoked for a minimum of five years after prescribing controlled substances for other than medically accepted therapeutic purposes.

Matthew Brennan, Chicago – temporary medical license issued on indefinite probation due to a substance abuse problem.

Cathy Coshal, Naperville – physician and surgeon license issued on probation for six years due to a history of substance abuse.

Charles Larue Johnson, Monument – physician and surgeon license placed on probation until August 1997 after being disciplined in the State of Colorado.

Suck OO Kim, Northbrook – physician and surgeon license placed on probation for two years and fined $1,000 due to gross negligence while employed as a pathologist.

Ruth Kopp, Adelstein – physician and surgeon license placed on probation for five years; controlled substance license suspended for one year followed by probation for five years due to an alleged history of alcohol and substance abuse problem.

Napoleon S. Maminta, Chesterfield, MO – physician and surgeon license indefinitely suspended after being disciplined in the State of Missouri.

Lyle Parks, Springfield – physician and surgeon license suspended until January 1, 1994, followed by probation for five years due to a criminal conviction.

September 1993

James E. Beckett, Des Plaines – physician and surgeon license issued on probation for twenty-one years after answering affirmatively to a personal history question on his application for licensure.

Eugene Brodsky, Chicago – physician and surgeon license indefinitely suspended for a minimum of 2 years; controlled substance license indefinitely suspended after allegedly ordering large quantities of controlled substances even though he was semi-retired and failing to keep legally required records to account for said drugs.

Ajay Kumar Das, Glenview – physician and surgeon license reprimanded after violating a previous Department ordered probation.

Efran C. Naguit, Belleville – physician and surgeon license indefinitely suspended for a minimum of one year followed by indefinite probation for a minimum of two years; controlled substance license indefinitely suspended for a minimum of two years followed by probation for three years for alleged multiple violations of the Illinois Medical Practice Act.

Mohammed Nasr, Lake Forest – physician and surgeon license reprimanded and fined $10,000 due to alleged unprofessional conduct.

Frederick Douglas Watson, Chicago – physician and surgeon license indefinitely suspended after practicing on a non-renewed license.

Stephen G. Weiss, Moline – physician and surgeon license placed on probation for one year after being disciplined in the State of Iowa.

October 1993

Sun Hwan Chi, Dubuque, IA – physician and surgeon license revoked due to a physical illness which results in the inability to practice with reasonable judgment, skill or safety.

Rene Z. Smith, Newcastle, OK – physician and surgeon license indefinitely suspended for a minimum of five years after being disciplined in the State of Missouri.

Shoh Kai Tan, Chicago – physician and surgeon license suspended for four months followed by probation for five years and fined $10,000 due to dishonorable, unethical and unprofessional conduct.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

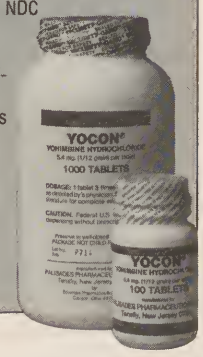
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Lawyer

(Continued from page 1)

the attorney dispersed only $113,688 to the children and their families.

The government accused Colantoni of spending more than $750,000 to cover expenses at his law firm and for his personal use. The balance was retained in law firm accounts, Dyer said.

Colantoni expressed remorse for his actions and admitted there was no excuse or justification for his behavior, according to his attorney, Richard Leng.

Dishonest attorneys are a disgrace to the country's legal system, Dyer said. "This victimization was especially onerous, as it occurred when the clients were least able to protect themselves, due to injury and grief. In addition to victimizing his clients, attorney Colantoni victimized the government program designed to protect those injured by vaccines."

Under the provisions of the federal Vaccine Act of 1986, HHS accepts liability for all required immunizations, including DTP, MMR and polio. Before the law was enacted, some pharmaceutical companies had stopped manufacturing vaccines because of high liability costs, and vaccine-injury victims had declared bankruptcy after paying legal fees incurred in seeking compensation, said Dyer. The VICP was created to allow victims or their estates to file administrative claims with the government instead of individual lawsuits against vaccine manufacturers, he explained.

To file a claim under the VICP, a patient must continue experiencing the effects of the injury six months after receiving the immunization, according to HHS. In addition, claims must be filed within 36 months after the first symptoms appear. Claims involving a death must be filed no later than 24 months after the patient dies and within 48 months of the injury. The filing deadline for claims that occurred before October 1988 was Jan. 31, 1991. Since then, only 78 cases have been filed with HHS, Dyer said.

THE U.S. JUSTICE Department represents HHS in the proceedings, and cases are usually settled quickly, said Dyer. Damages are drawn from the general treasury and an excise tax on vaccines. "HHS made it a very short process. The plaintiff chooses an attorney, and the government covers the attorney's fees up to $30,000 per case."

Plaintiffs may choose from two payment options – an annuity or a lump sum payment, Dyer said. If they choose the single payment, a check is sent to the attorney to distribute. Dyer explained that Colantoni told his clients that he had not received the checks.

To prevent such fraud, HHS reviewed the vaccine program and made changes, Dyer said. "First of all, we use the annuity payments as much as possible, because the attorney is really not involved in [that] process. And in instances where the plaintiff insists on a lump sum payment, we now send a separate confirmation to the plaintiff indicating the money has been sent to the lawyer."

Vaccines are safe but not completely without risk, Dyer said. "However, the risk of injury from vaccines is far less than injury from the disease itself. I would hope the publicity concerning these charges would not compound the tragedy by discouraging anyone from utilizing vaccines." ■



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(Continued from page 7)

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All claims are reviewed by PRC for settle-or-defend decisions. "PRC operates under the philosophy that in a lawsuit, not only is the named defendant being sued, but the whole company as well," Dr. Clementi said, adding that ISMIE works hard to resolve actions in policyholders' best interests.

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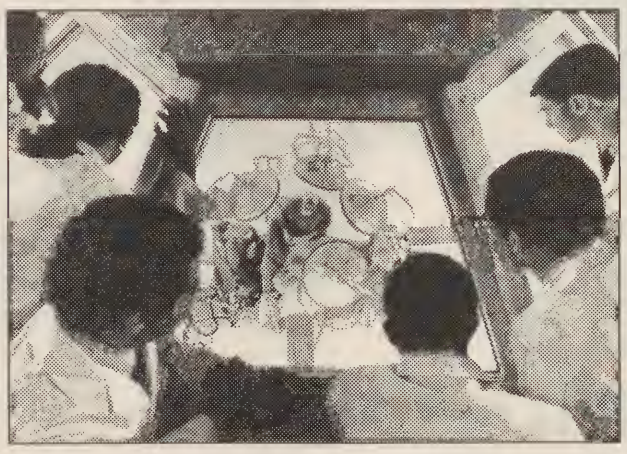
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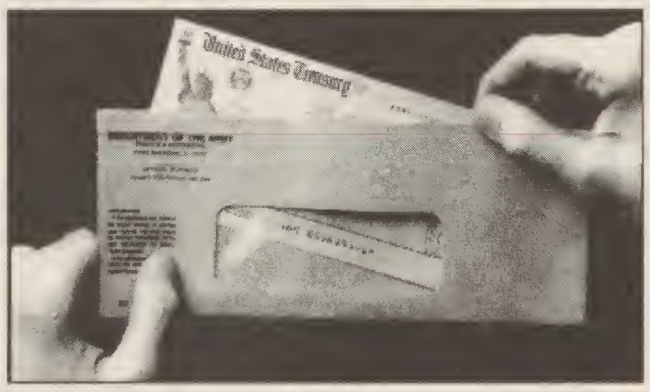
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Gun control

(Continued from page 1)

were killed in the city in 1983 with semiautomatic pistols and assault weapons. In 1992, 297 people were killed by individuals using assault-type weapons.

Patients experience more tissue destruction in wounds inflicted by semiautomatic and automatic weapons, Dr. Barrett said, explaining that as the velocity of a bullet increases, so does the severity of an injury. Rather than firing a single bullet, some assault weapons are capable of spraying 15 bullets at a time, he noted. Victims are more likely to die of their wounds or require operative intervention and intensive care. They also develop more infections, Dr. Barrett added. "Automatic weapons place an incredible burden on the medical infrastructure. Our ICU beds are constantly full. Whatever we can do [to stop violence] will help. We can't go on like this."

To help position gun violence as a public health problem, CMS President Sandra F. Olson, MD, sponsored the county medical society resolution. The physician-endorsed measure would not apply to sporting weapons or weapons used by law enforcement and security personnel.

Like CMS, ISMS has policy supporting the rights of counties and municipalities to enact ordinances banning the possession of firearms.

CMS also formed a special committee charged with developing educational resources and programs to help physicians recognize, treat and prevent the effects of violence on their patients.

Now that the public is finally becoming outraged by the scope of violence in our society, it is a good time to begin adopting stringent anti-gun measures, Dr. Olson said.

Dr. Barrett said he believes public support for gun control increased once the media focused its attention on children as victims of violent crime. "Before that, people thought that if someone was shot, he probably deserved it."

Dr. Olson and Dr. Barrett contend that for gun control legislation to be effective, it must be enacted at the federal level. "We need a national effort to make a universal policy," Dr. Olson said. State gun laws vary, enabling individuals to purchase weapons in one state and transport them to another state that might ban guns, she noted.

> *We've got to get guns off the street.*

Dr. Barrett said he recommends an educational campaign to teach schoolchildren that violence is unacceptable and provide them with coping mechanisms to deal with anger more constructively. But such teaching efforts "will take a generation before they have any effect," he added. In the meantime, Dr. Barrett said, "We've got to get guns off the street." ■

Tie one on

(Continued from page 1)

go, that figure is closer to 60 percent, said Gary J. Merlotti, MD, director of the hospital's trauma services. "Drunken driving is a major public health problem. About 70 percent of our trauma admissions are motor vehicle accident [victims], and 60 percent of those are above the legal [blood alcohol level] limit. That's about 1,200 victims per year, and that doesn't even count the nonintoxicated, innocent victims."

In addition, the costs related to drunken driving are tremendous, Dr. Merlotti added. "Everyone always talks about the cost of gunshot wounds, but we lose more money on drunken driving victims, who are usually young, uninsured and have more global injuries. They spend two weeks in [the intensive care unit] and then two months in rehabilitation. On the other hand, a gunshot victim goes to surgery and then goes home in a week. Our biggest expenditure is drunken driving, and I don't think our society can tolerate this any longer."

According to NHTSA estimates, alcohol-related crashes cost society a total of $46 billion annually. In 1990, the health care bill alone for such incidents was $5.5 billion, accounting for 37 percent of nonfatal injury costs and 53 percent of fatal injury costs.

Hospital emergency departments are busiest with drunken driving victims in the summer and on weekends and holidays, Dr. Merlotti said. ER physicians also see many repeat offenders who are never prosecuted, said Leslie S. Zun, MD, clinical chairman of the emergency medicine department at Chicago's Mt. Sinai Hospital Medical Center.

"Something is wrong." said Dr. Zun. "Drunken driving is against the law, but that law is not enforced. It is very, very rare that I see someone prosecuted for drunken driving, and I don't know why. I don't know whether this is an issue for the police or the state's attorney's office. As physicians, we can refer [intoxicated drivers] to treatment programs. But everyone has a role in this; everyone must play his or her role."

ISMS House of Delegates policy supports laws calling for appropriate sentencing of drunken drivers and encourages the judiciary to recommend rehabilitative treatment to deal with people convicted of driving under the influence.

Displaying a MADD red ribbon is an easy way for everyone to get involved in the fight against drunken driving, said Gary March, director of the Illinois Department of Transportation's traffic safety division. "I hope that all people will – in addition to remembering the victims that MADD so diligently represents – consider this ribbon to represent the thousands of late-night telephone calls that were not received by thousands of families over the last decade. We have no way of knowing who was spared this grief, so we must all consider that it was ourselves, our families, our friends, and display this red ribbon in that spirit over the holiday season."

For information about MADD or Project Red Ribbon, call (312) 782-6626. ■

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